COMBINED PROJECT INFORMATION DOCUMENTS / INTEGRATED SAFEGUARDS DATA SHEET (PID/ISDS)
CONCEPT STAGE

Report No.: PIDISDSC15275

Date Prepared/Updated: 19-Oct-2015

I. BASIC INFORMATION

A. Basic Project Data

Country:	Sierra Leone	**Project ID:**	P153064
		Parent Project ID (if any):	
Project Name:	Health Service Delivery & System Support Project (P153064)		
Region:	AFRICA		
Estimated Appraisal Date:	07-Dec-2015	**Estimated Board Date:**	26-Jan-2016
Practice Area (Lead):	Health, Nutrition & Population	**Lending Instrument:**	Investment Project Financing
Sector(s):	Health (50%), Other social services (50%)		
Theme(s):	Health system performance (50%), Population and reproductive health (35%), Other human development (10%), Child health (5%)		
Borrower(s):	Ministry of Finance and Economic Development		
Implementing Agency:	Ministry of Health and Sanitation		

Financing (in USD Million)

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	30.00
Total Project Cost	30.00

Environmental Category:	B - Partial Assessment
Concept Review Decision:	Track II - The review did authorize the preparation to continue
Is this a Repeater project?	No
Other Decision (as needed):	

B. Introduction and Context

Country Context

Following the end of the civil war in 2002, Sierra Leone experienced a period of rapid growth, due largely to political stability and the return of large numbers of the population to agriculture and related activities. GDP increased nearly 6 percent annually through 2010. More recently, the growth of the iron ore industry, with large inflows of Foreign Direct Investment and exports of new iron ore production raised annual GDP growth rates to an average 17.6 percent from 2010 to 2013. Substantial potential exists for further development of the country's mineral resources and commercial agriculture and fishing.

At the end of 2013, an IMF program review noted that management of the economy had been effective in achieving growth and macroeconomic stability, as reflected in single digit inflation rates, reduced external current account deficit, and increased financial reserves at the end of the year. The review cautioned, however, that the small revenue base and persistent pressures on government expenditure could threaten this stability, as was subsequently demonstrated by the derailing of the government's economic program during the recent Ebola epidemic.

The government's national development plan ("Agenda for Prosperity") has established the ambitious goal of achieving middle income country status by 2035 with annual per capita expenditure growth targets of 4.8 percent. However, the Systematic Country Diagnostic (SCD) currently under preparation notes that per capita growth of this magnitude would require GDP growth of around nine percent annually, substantially higher than the average 6.4 percent achieved between 2003 and 2013.

Poverty has declined among Sierra Leone's approximately six million residents (from 66.4 percent in 2003 to 52.9 percent in 2011), but the number of poor has remained essentially constant (around 3 million) due to higher rates of fertility. More than three-quarters of the poor live in rural areas with relatively small regional differences between rural areas across the country. Sierra Leone regularly places at the bottom of global rankings of well-being: the United Nation's 2014 Human Development Index ranked Sierra Leone 183rd out of 187 countries and territories.

The Ebola epidemic of 2014 devastated the country: as of September 15, 2015 13,756 cases and 3,953 deaths had been recorded in Sierra Leone. Among the direct victims of the epidemic were 446 children; another 8,345 children were orphaned and more than 1,100 households were left with a single parent. Apart from the direct human cost in terms of lost lives and livelihoods, the epidemic is having a disproportionately large effect on economic activity, and the SCD indicates a decline (from the mid-year projection of an 11.3 percent increase in real GDP) of around 5 percentage points for economic growth in 2014. While preliminary information suggests that the economic effects of Ebola in 2014 were partially offset by continued rapid expansion in the iron ore sector (albeit at slower than expected rates), both the effects of the iron ore sub-sector difficulties of late 2014 and the trajectory and timing of an economic recovery from the epidemic remain unclear.

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

in the hard-hit non-farm self-employment sector.

Sectoral and Institutional Context

Health care expenditures in Sierra Leone are significant: (i) from 2004 through 2012, total health expenditure as a percent of GDP ranged between 14 percent and 16 percent; and (ii) per capita spending on health increased from $69 (2010) to $82 (2011) to $96 (2012) or between two to three times the amounts recommended by WHO guidelines. In addition, as a priority of "The Agenda for Prosperity", Government allocations to the health sector increased from 8.2 percent in 2010 to 11.2 percent in 2013. Overall, however, Government expenditures represent only 6.8 percent of total health expenditures (THE). Donor financing accounts for 24.4 percent, NGO funding for 7.2 percent, and out of pocket (OOP) for 61.6 percent.

Despite these overall expenditures, health outcomes are worse than in countries with comparable socio-economic characteristics. Sierra Leone's maternal and child health outcomes remain among the world's worst: (i) maternal mortality is estimated at 1,165 per 100,000 live births; (ii) infant mortality is estimated at 92 per 1,000 live births; and (iii) under five mortality is estimated at 156 per 1,000 live births . These results are far from the Millennium Development Goals (MDG) of 450 per 100,000 live births, 50 per 1,000 live births, and 95 per 1,000 live births, respectively expected by the end of 2015.

The maternal mortality ratio steadily declined through 2008; but, according to the recent Demographic Health Survey (DHS), the maternal mortality rate increased from 857 per 100,000 live births in 2008 to 1,165 per 100,000 live births in 2013. Other reproductive health indicators have improved over the 2008-2013 period: (i) the proportion of pregnant women seeking antenatal care reached 97 percent in 2013; (ii) institutional delivery and delivery by trained health workers increased from 42.4 percent to 59.7 percent; and (iii) fertility rates among adolescents (15 to 19 years old), while high, have declined slightly from 149 per 1,000 women to 125 per 1,000 women. Contraceptive prevalence remains very low at 16 percent.

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

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

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

Responsibilities for delivering public health services are divided between the Ministry of Health and Sanitation (MoHS) at the central and district levels and the Local Councils at the community level. In theory, MoHS is responsible for overall strategic direction, resource mobilization, and

monitoring and evaluation of health services, while the Councils are responsible for primary health service delivery at the periphery. In parallel, the District Health Management Team (DHMT), the Ministry's representation at the district level (headed by the District Medical Officer), are responsible for planning, organizing, managing, implementing, monitoring and supervising all health programs in the district, under Local Councils oversight. In practice, however, the decentralization process has only been partial, and Local Councils have little capacity to fulfill their functions, which are being carried out by MoHS. As devolution of sectorial staff was never implemented - that is, MoHS still recruits, posts, manages and pays sectorial staff – Local Councils have no direct control over the staff responsible for health service delivery and the DHMT, which tends to report directly to its parent ministry.

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

Prior to the Ebola epidemic, the health sector faced many critical foundational challenges, including: (i) inadequate capacity for effective implementation, coordination, monitoring and evaluation of policies and projects; (ii) an insufficient and unevenly distributed workforce and inadequately equipped health facilities; (iii) a fragile logistic and supply system; and (iv) an inadequate surveillance and emergency preparedness capacity. The epidemic has since left Sierra Leone's already weak health system with three important problems. First, though 96 percent of primary health units remained open during the epidemic, community confidence in the health sector declined, negatively affecting utilization, with drops of 23 percent in institutional deliveries, 21 percent in children receiving basic immunization (penta3), and 39 percent in children treated for malaria. Second, increased expenditures for the Ebola response have reduced the resources available for the health sector to deal with other normally treatable conditions leading to increases in malaria, measles and other vaccine preventable diseases. Third, as reported recently in a Bank Working Paper, the loss of health care workers is expected to have a significant impact on future non-Ebola mortality: after Ebola is eliminated, the Bank review estimates that maternal mortality could increase by 74 percent in Sierra Leone unless key doctors, nurses, and midwives are immediately hired.

Relationship to CAS/CPS/CPF

The existing Country Assistance Strategy (CAS) for the period 2010-2013 emphasizes Human Development as one of the two principal pillars and focused on investments to support decentralized delivery of reproductive and child health services to address maternal and child mortality. The proposed project would be entirely consistent with these priorities. A new Country Partnership Framework (CPF) is being developed and as part of the CPF process, a draft of the Systematic Country Diagnostic (SCD) has been prepared and the CPF will be available during FY16.

The third Poverty Reduction Strategy Paper (PRSP-3), entitled "An Agenda for Prosperity," was adopted in 2013 for the period 2013-18 with the aim of promoting inclusive growth, economic diversification and value-addition. Based on a development strategy linked to natural resources

(large scale iron ore mining and offshore oil exploration), the Agenda for Prosperity optimistically envisioned the achievement of middle income country status by 2035.
Pillar 3 (Accelerating Human Development) emphasizes health, HIV/AIDS, water, and environmental sanitation and hygiene in particular. Initiatives to offer free health care and scale up nutrition activities feature prominently in the President's introductory message and in the vision for 2035. Pillar 8 (Gender and Women's Empowerment) also includes elements contributing to the health of women and girls.
As a consequence of the epidemic, implementation of the Agenda has been temporarily suspended. Currently, the Government's Recovery and Transition Plan (April 2015) includes a broad range of priorities (health, education, social protection, etc.); and a 2-year plan is being prepared to return the country to the Agenda for Prosperity. MoHS has also prepared a post-Ebola Health Sector Recovery Plan (2015-2020), which comprises three overlapping phases: Early Recovery (July 2015-March 2016), Recovery (January 2016-December 2017), and health system strengthening and resilience building (2018-2020).
The Bank's pre-Ebola experience in the health sector of Sierra Leone dates to the 1980's and encompasses both health service delivery and health systems development (and decentralization). The current Reproductive and Child Health Project (RCHP 2) has since 2010 supported the Local Councils with grants to finance inputs and training (the need-based portion of the grant) and outputs (the performance-based portion of the grant). Additional financing was approved in 2013 to (i) strengthen the existing primary health care performance-based financing (PBF); (ii) extend PBF to private primary health care (PHUs) providers; and (iii) scale up the PBF mechanism from two to eight hospitals. In 2014, the project was restructured to reallocate project funds in response to the Ebola epidemic.
Currently, several related operations provide instruments for the Bank's response to the Ebola epidemic: (i) the Reproductive and Child Health Project (RCHP2); and (ii) the Emergency Ebola Response Project (EERP), and the Ebola Recovery Reconstruction Trust Fund (ERRTF). . The EERP is supporting the getting to zero/response and early recovery phase while the EERTF is supporting the early recovery and parts of the recovery phases. In addition to these projects and the proposed HSDSSP, the Bank is also currently preparing a regional project to strengthen public health laboratory and disease surveillance capabilities throughout West Africa, including Sierra Leone and the other Ebola-affected countries. Many other development partners are also actively involved in the post-Ebola planning and implementation process; these include the UN agencies (WHO, UNICEF, UNFPA, etc.), multi-lateral and bilateral agencies (Global Fund, AfDB, DfID, USAID, etc.), and foundations and non-governmental organizations.

C. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

The project development objective (PDO) of the Health Service Delivery and System Support Project is to increase the utilization and improve the quality of essential maternal and child health services in selected districts in the country.
Concretely, the project will support service delivery through the provision of various inputs including health systems strengthening actions particularly in human resources as well as several national interventions (such as DHMT capacity-building) which will be implemented in selected districts and expansion of piloted initiatives. The project will measure (i) health service delivery outcomes at the objective level and (ii) health systems strengthening outputs at the intermediate outcomes level as part of the Government's post Ebola recovery effort. Because achievement of measurable change in health systems development and health service delivery requires more time than envisaged by the project, PDO level indicators will necessarily be: (i) limited in scope to the

3 year implementation period of the project; (ii) linked to the specific support being provided; and (iii) measured by indicators that are intermediate-level or process oriented in nature.

Key Results (From PCN)

The National Health Sector Strategic Plan 2010-2015 (NHSSP) and the Basic Package of Essential Health Services (BPEHS) continue to provide the strategic and programmatic direction for the sector during the post-Ebola Health Sector Recovery period. NHSSP focuses on the key pillars of health systems strengthening while BPEHS comprises more than a dozen health service interventions. The Results and Accountability Framework (2012) links the health systems strengthening and health services delivery components and provides a list of the expected results. Relevant (and measurable) indicators from the Results and Accountability Framework will be adapted for the proposed project. Indicatively, project performance would be evaluated on the basis of: (i) increased access (as measured by availability and affordability) and utilization; and improved quality of essential maternal and child health services at peripheral health units and district hospitals (as measured by the safety measures implemented, the conformity of services provided with revised norms, and the efficacy of the services provided). In addition to the core indicators, the key results indicators will be determined during preparation but are likely to include :

- Project beneficiaries (direct, female, and children under five)
- Pregnant women receiving two or more ANC services (percentage/number)
- Percentage of the population residing within 5 km of a health facility or % of population living within 5 km of facility offering Basic or Comprehensive Emergency Obstetric and Newborn Care (BEmONC or CEmONC) services
- Number/Percentage of facilities assessed as 80% IPC compliant
- Number of key health professionals by cadre per 100,000 population
- Percentage of deliveries attended by a skilled birth attendant
- Number/Percentage of children receiving Penta-3 before 12 months of age
- Some combination of Malaria, HIV, TB, and/or Nutrition related indicators

Other key process indicators linked to the project's support to health system strengthening will be identified and refined during preparation, once the project's components and sub-components have been agreed on. These will most likely include improved methods and tools for health systems management (e.g., performance-based financing, service level agreements, etc.) and new approaches to enhance institutional capacity at health facility and district management levels (e.g., training, coordination, information, etc.).

D. Concept Description

To date, the Bank-financed Ebola Emergency Response Project (EERP) has provided support to the Response and Early Recovery phases of the Government's post-Ebola Health Sector Recovery Plan (2015 to 2020). The plan comprises three overlapping phases: Early Recovery (July 2015-March 2016), Recovery (January 2016-December 2017), and health system strengthening and resilience building (2018-2020) and addresses five key priorities: (i) patient and health worker safety; (ii) health workforce; (iii) essential health services; (iv) community ownership; and (v) and information and surveillance.

The proposed health project will complement Bank and other sources of funds in supporting the post Ebola response. Specifically, over the next 24 to 36 months, project financing of US$ 30 Million will support the Recovery and Resilience phases by addressing two essential components: (i) district health services delivery; and (ii) human resources for health. The project will also

support project management and monitoring and evaluation.

The PDO will be achieved: (i) by strengthening ongoing and tested approaches to improved organization and delivery of health services at the district level; and (ii) by measures to support the establishment of additional cadres of health personnel to increase the numbers and improve the quality of these personnel. As Component 1 reinforces existing interventions, its impact on the recovery process should be measurable within the duration of the project. However since Component 2 addresses health human resources issues which take time given the length of the training and other complexities, its impact will probably not be measurable until after the end of the project. The support to be provided by the project in this area are of a foundational nature essential to achieving the impact. It is also important to allow some flexibility in the design of this project given the dynamic and ongoing nature of the post Ebola recovery planning efforts which is being led by Government and involving many other donor and development partners

Component 1: District Health Services Delivery Support (estimated cost: US$ 20.0 Million). This component will comprise four subcomponents to enhance the delivery of health care services at the district level: (i) building the technical and managerial capacity of health staff and district staff to deliver essential maternal and child health services; (ii) supporting the Service Level Agreement initiative to improve coordination and accountability of donor supported efforts at the district level; and (iii) accelerating the roll out of the ongoing Performance-Based Financing Plus Initiative to improve facility supervision, quantity and quality of services, autonomy and community involvement in service delivery. In addition, the technical capacity of health facilities will be strengthened by the establishment of a National Ambulance Service.

(a) District Capacity Strengthening (estimated cost: US$ 10.0 Million). This component will contribute to the Government's flagship program by: (i) building technical and managerial capacity of health staff at the district hospital and peripheral health unit levels; and (ii) reinforcing health service leadership and coordination at the district level. At the hospital and peripheral health unit levels, Foreign Medical Teams (FMT) will be recruited and deployed to strengthen the technical capacity of local staff to deliver quality high impact services to address maternal and child health challenges. Multi-disciplinary clinical teams of 7 (comprising a gynecologist, surgeon, anesthetist, family physician, pediatrician, midwife and PHC Nurse) will be posted in each of the 4 major district hospitals. In each of the other 8 district hospitals a clinical team of 7 (comprising 5 medical officers, midwife and PHC nurse) will be posted. The midwives and PHC nurses will devote a large portion of their time to mentoring and coaching of PHU staff.

A community outreach component with a structure of 8-10 community health workers attached to one nurse will be deployed at chiefdom level (with a planned gradual increase) to support the PHUs through outreach activities. Community outreach teams will conduct sensitization aimed at improving health knowledge and health-seeking behavior. The project will finance training and incentives for the outreach teams and support the deployment of supervisors to enhance supervision of community health workers by PHUs.

At the district level, a health management officer will be recruited to work closely with the District Medical Officer (DMO) and the District Health Management Team (DHMT) to facilitate the transfer of management and leadership skills. The initiative will include regular monitoring of the district's health situation and weekly district meetings to review key health outputs, assess indicators of service utilization and quality, and inform decision-making on solutions to enhance health facility performance.

(b) Service Level Agreement (estimated cost: US$ 1.0 Million). Launched by the President of Sierra Leone in July 2015, Service Level Agreements will be signed between the health implementing partners (IPs) and health authorities at the central, district, and local levels. For each project implemented by nongovernmental organizations and other stakeholders in the health

sector, IPs will submit a project plan and an annual performance plan for approval by MoHS. SLAs are intended to ensure the consistency of planned interventions with MOHS's priorities, improve coordination between MoHS and its implementing partners (IPs), and hold IPs accountable for results of their activities. Implementation of the SLA will be subject to regular monitoring through: (i) quarterly reports submitted by the IP to MoHS; and (ii) semi-annual joint monitoring visits involving MoHS, the IP, districts, and the donor.

(c) Performance-Based Financing (estimated US$ 6.0 Million). With Bank support under the ongoing Reproductive and Child Health Project (RCHP 2), the MoHS has been implementing PBF as part of the Free Health Care Initiative since 2010. The scheme has helped to increase utilization of maternal and child health care services in over 1200 PHUs nationally and in two hospitals in Freetown. However, in the absence of a scale-up strategy allowing for operational research, ensuring service quality has proved challenging. An external evaluation conducted by Cordaid (2014) indicated shortcomings in the initial design and implementation including weak verification mechanisms, payment delays, limited funding, lack of a comprehensive list of output and quality indicators, inadequate autonomy of health facilities, very weak involvement of the communities and the limited usage of PBF management instruments. In January 2015, a full-fledged, improved PBF system to address these shortcomings was recommended as a part of the post- Ebola recovery plan.

MoHS has since updated the design of the original PBF scheme and is currently implementing the “PBF PLUS” as a pilot in Bombali District in over 100 PHUs and in the district hospital in Makeni. EERP will support the PBF PLUS Pilot through the first quarter of 2016, and this new project will finance the roll-out of the pilot model to one or two more districts over the subsequent 2-3 years to allow for additional learning to help the Government better plan to the national roll-out of the improved scheme.

(d) Emergency Medical Services (estimated cost US$ 3.0 Million). As a part of the Ebola response, hundreds of ambulances were donated to Government to facilitate the transfer of suspected EVD cases to Ebola treatment centers. Capitalizing on these investments and with initial support from the ongoing EERP, this component will support the establishment of a functional national ambulance service to improve service delivery, especially for emergency obstetric care.

It is envisaged that the management of the ambulance service will largely be contracted out to the private sector, and the Bank's IFC Team is already supporting the proposed PublicPrivate Partnership aspect of this initiative. In addition, to ensure the equitable coverage and affordability of the service, MoHS intends to regulate services through a National Ambulance Commission. The component will contribute to training (of at least 500 paramedics and 200 ambulance drivers), construction of a depot for ambulance storage, and decontamination and maintenance services.

Component 2: Human Resources for Health (estimated cost: US$ 8.0 Million). This component will comprise subcomponents to fill quantitative and qualitative gaps in three key areas of health workforce skills: specialized medical training, community health, and environmental health.

(a) Clinical Residency Training (estimated cost: US$ 3.0 Million). Except for midwifery, MoHS relies on foreign medical schools to provide post-graduate clinical residency training to the government's health workforce. Because Sierra Leonean medical personnel often choose to remain abroad after receiving their training, there have been substantial losses. To reverse this trend, this component will support the Post-Graduate Medical Training Initiative; specialists will be trained locally, increasing the number of specialized staff able to provide high quality tertiary care and to transfer skills to junior medical officers.

Local specialist training will be established through the Sierra Leone Post-Graduate College of

Medical Specialties (SLPGCMS) and the University Teaching Hospital Complex (UTH). MoHS has drafted legislation to create the SLPGCMS and the UTH Complex; concurrence has been received from the Ministry of Finance and Economic Development (MOFED) and is expected from the Ministry of Education, Sciences and Technology (MEST). Both bills have been approved by the Cabinet and will be submitted to Parliament for ratification. As part of the development of the bills, MoHS has determined the Board composition and will need to develop the Board operating procedures and further refine the Departmental structures for the UTH. The project would support their initial set-up with technical assistance in organization, management, and budget planning.

(b) Community Health Officer Training (estimated cost: US $3.0 Million). The shortage of health staff in most personnel categories is exacerbated by the high concentration of health workers in urban areas, and especially in Western Area Urban District. The Government has promoted several strategies to ensure service delivery in remote areas, including: (i) allowances for staff deployed in rural areas; (ii) use of Community Health Officers (CHOs) to manage community health posts; and (iii) reliance on community health workers to provide services. Of these options, the use of CHOs seems the most promising, and MoHS initiated the creation of a School of Clinical Sciences in Makeni to conduct CHO training.

Shortly after constructing the initial block of buildings, however, the School was turned into an Ebola treatment unit as part of the outbreak response efforts. MoHS has proposed a plan to: (i) finalize construction (including boarding facilities) and procure equipment; and (ii) organize teaching, management, and administration. MOHS plans to enroll the first intake of CHOs for the North in 2016. The MOHS will further refine the concept and submit a proposal for the Bank's consideration.

(c) Public Health Aide Training for Environmental Health (estimated cost: US $ 2.0 Million). Given the lack of safe water and sanitation (especially in rural areas), MoHS proposes to support the local councils in reintroducing and maintaining the Public Health Aides (PHAs). PHAs would be responsible for inspecting the sanitary conditions of the community, proposing recommendations for improvement, advising families on how to access assistance necessary to achieve that improvement, and monitoring/enforcing compliance with the recommendations. MoHS would conduct refresher courses for 200 previously trained PHAs, deploy them to districts throughout the country, support the district's monitoring effort by providing motorbikes, and support incentive payments. MOHS will further refine the concept and submit a proposal for the Bank's consideration.

Component 3: Project Management and Monitoring and Evaluation (estimated cost: US $ 2. 0 Million). To enhance the organization and management of MoHS, RCHP 2 and other projects have supported the establishment of the Integrated Health Project Administration Unit (IHPAU). Under the supervision of the Permanent Secretary and with linkages with the MoHS directorates, the seven staff of IHPAU were expected to provide oversight of all externally financed projects with a view to improve planning, control, and implementation. However, a change of ministers and a revision of the MoHS structure have led to proposed changes of the IHPAU; in consultation with partners, including Global Fund, WHO, DFID, and the Bank, IHPAU will now comprise five positions: Fund Management Specialist/Team Lead; Finance Specialist; Procurement Specialist; Audit Specialist; and Monitoring, Evaluation, Accountability and Learning (MEAL) Specialist. RCHP 2 and EERP will finance the five specialists until the end of 2015, and future financing will be shared across key donors from 2016 including GFATM, DfID, and the UN. The new project will finance the Bank's portion of the costs.

II. SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The project will be implemented nationwide in Sierra Leone: some programs will cover all the districts, while most other programs are not location specific. Project activities include construction (depot for ambulance storage; storage and maintenance of vehicles) and rehabilitation/renovation and/or extension (of the school of Clinical Sciences or Post-graduate school). Project activities also include improving and strengthening provision of medical services and environmental health and sanitation. In those project sites where civil works will be undertaken within existing structure/ compounds/boundary, the primary environmental issues will relate to management of construction waste construction and occupational and patient access and safety. In case the site is new, the issues related to land ownership and its natural state and location may require additional due diligence procedures to be undertaken which will be determined during preparation mission. With regard to the other project activities, the key issues are related to infection control and management of infectious healthcare waste. Enhancement measures (in a do-good approach) related to improving environmental health and sanitation can be determined according to the specific activities which are to be financed under the project.

B. Borrower's Institutional Capacity for Safeguard Policies

The legislative and institutional framework for environmental protection is relatively recent in Sierra Leone and a National Environmental Health Policy of 2000 is currently under review. The Government of Sierra Leone has been implementing World Bank funded health projects and knows the requirements with regard to the preparation of the environmental and social safeguards documents. However, implementation has been weak, as is apparent from the current situational analysis of the health sector projects. The capacity of the MOHS remains weak with regard to environmental and social due diligence and implementation. There will be need under this project to provide capacity building focused on infectious waste management, occupational health and safety along with enhancing the capacity of the MOHS to further improve environmental health and sanitation. Management capability of construction as related to environmental and social safeguards measures will also need to be strengthened.

C. Environmental and Social Safeguards Specialists on the Team

Demba Balde (GSURR)

Ruma Tavorath (GENDR)

D. POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Impacts are expected from proposed minor facility rehabilitation civil works & provision of medical services. Since the mitigation measures of these activities are well-defined & understood & manageable, the project is rated as category B. Potential environmental impacts include:clearance of trees on sites, dust emissions, disruption of health services; safety of workers and access of patients and community to services etc. An ESMF will be prepared to provide mitigation for potential impacts.

Natural Habitats OP/BP 4.04	No	Project activities are not expected to affect natural habitats.
Forests OP/BP 4.36	No	Project activities will not intrude upon and will not have any impacts on forest areas.
Pest Management OP 4.09	No	Project activities are not expected to procure or utilize pesticides or insecticides.
Physical Cultural Resources OP/BP 4.11	No	Project activities will most likely not be undertaken on new land where there is possibility of presence of PCR.
Indigenous Peoples OP/BP 4.10	No	There are no Indigenous Peoples in the project area.
Involuntary Resettlement OP/ BP 4.12	TBD	The project will involve rehabilitation & new constructions on existing land owned by Government. The specific programs concerned are the Emergency Medical Service (construction of structure for the storage & maintenance of vehicles) & the School of Clinical Sciences (rehabilitation of & construction of additional structures). No physical displacement is currently expected under the project. No land acquisition is currently expected which will be confirmed during preparation mission.
Safety of Dams OP/BP 4.37	No	Project activities will not entail construction of dams, nor rely on dams.
Projects on International Waterways OP/BP 7.50	No	Project activities do not have any impact on international waterways.
Projects in Disputed Areas OP/ BP 7.60	No	There are no project activities in any disputed areas.

E. Safeguard Preparation Plan

1. Tentative target date for preparing the PAD Stage ISDS

30-Nov-2015

2. Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the PAD-stage ISDS.

Since the project sites are under consideration and there could be multiple different types of small constructions and civil works, the project will require an Environmental and Social Management Framework (ESMF) that defines procedures, processes and mitigatory measures to be put in place prior to construction. Since the project activities also include generation of infectious healthcare waste, a Healthcare Waste Management Plan (HCWMP) will also need to be prepared.

III. Contact point

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V. Approval

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Approved By		
Safeguards Advisor:	Name: Johanna van Tilburg (SA)	Date: 19-Oct-2015
Practice Manager/ Manager:	Name: Trina S. Haque (PMGR)	Date: 21-Oct-2015
Country Director:	Name: Henry G. R. Kerali (CD)	Date: 23-Oct-2015

1 Reminder: The Bank's Disclosure Policy requires that safeguard-related documents be disclosed before appraisal (i) at the InfoShop and (ii) in country, at publicly accessible locations and in a form and language that are accessible to potentially affected persons.