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Report No: 40881-SL

PROJECT APPRAISAL DOCUMENT

FOR A

PROPOSED AFRICA CATALYTIC GROWTH FUND GRANT

IN THE AMOUNT OF USD 6.0 MILLION

TO THE

REPUBLIC OF SIERRA LEONE

FOR

PHASE I

OF A

REPRODUCTIVE AND CHILD HEALTH PROJECT

November 9, 2007

Africa Catalytic Growth Fund
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective August 2007)

Currency Unit = Leone (Le)
3000 Le = US$1

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ACGF	Africa Catalytic Growth Fund
ACTs	Arteminisin-based Combination Therapy
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Anti-natal Care
APL	Adaptable Program Lending
ART	Anti-retroviral therapy
BP	World Bank Procedure
CAS	Country Assistance Strategy
CDMAP	Africa Region's Action Plan to Support Capacity Building
CHP	Community Health Post
DFID	Department for International Development
DHMT	District Health Management Team
DHS	Demographic Health Survey
DMO	District Medical Officer
DPI	Director of Policy Planning and Information
DPT3	Diphtheria, Pertussis and Tetanus 3
EPI	Expanded Program of Immunization
FM	Financial Management
FY	Fiscal Year
GDP	Gross Domestic Product
GOSL	Government of Sierra Leone
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMN	Health Metrics Network
HSRDP	Health Sector Reconstruction and Development Project
IDA	International Development Association
IEC	Information, Education and Communication
IFR	Interim Financial Report
IPT	Intermittent Presumptive Treatment
IRCBP	Institutional Reform and Capacity Building Project
ITN	Insecticide Treated Net
LC	Local Council
LGDG	Local Government Development Grant
LGFD	Local Government Finance Department
M&E	Monitoring and Evaluation
MBB	Marginal Budgeting for Bottlenecks
MCH	Maternal and Child Health
MCHP	Maternal and Child Health Post
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MOF	Ministry of Finance
MOHS	Ministry of Health and Sanitation

NGO	Non-Governmental Organization
NHPAC	National Health Policy Advisory Committee
NSCSRCH	National Steering Committee for Sexual, Reproductive and Child Health
OP	World Bank Operational Policy
PAD	Project Appraisal Document
PDA	Personal Digital Assistant
PHC	Primary Health Care
PHU	Peripheral Health Unit
PPA	Project Preparatory Advance
PRSP	Poverty Reduction Strategy Paper
TB	Tuberculosis
TBA	Traditional Birth Attendant
TOR	Terms of Reference
U5MR	Under-Five Mortality Rate
UN	United Nations
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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Reproductive and Child Health Project

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REPRODUCTIVE AND CHILD HEALTH - PHASE I

PROJECT APPRAISAL DOCUMENT

AFRICA

AFTH2

Date: November 9, 2007	Team Leader: Laura L. Rose
Country Director: Ishac Diwan	Sectors: Health (100%)
Sector Manager/Director: Eva Jarawan	Themes: Child health (P);Population and reproductive health (S);Health system performance (S);Decentralization (S)
Project ID: P103712	Environmental screening category: Partial Assessment
Lending Instrument: Trust Fund Grant	

Project Financing Data

[ ] Loan [ ] Credit [X] Grant [ ] Guarantee [ ] Other:

For Grants:
Total Operation Cost (US$m.): 6.00

Financing Plan (US$m)

Source	Local	Foreign	Total
Borrower	0.00	0.00	0.00
Africa Catalytic Growth Fund (ACGF)	3.94	2.06	6.00
Total:	3.94	2.06	6.00

Amount of financing to be provided by

Source	Amount (US$m)
Trust Fund	6.00
Special Financing	0.00
Recipient	0.00
External Funds, not Bank Managed	0.00
Financing Gap	0.00
Total Project Cost	6.00

Recipient:
Republic of Sierra Leone

Responsible Agency:
IRCBP Coordinating Unit
Bank of Sierra Leone Building
Freetown

Sierra Leone
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Ministry of Health and Sanitation
4th Floor Youyi Building
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Estimated disbursements (Bank FY/US$m)									
FY	2008								
Annual	6.00								
Cumulative	6.00								

Project implementation period: Start: January 1, 2008 End: June 30, 2008
Expected effectiveness date: December 15, 2007
Expected closing date: June 30, 2008

Does the project depart from the CAS in content or other significant respects?	[ ]Yes [X] No
Does the project require any exceptions from Bank policies?	[ ]Yes [X] No
Have these been approved by Bank management?	[ ]Yes [X] No
Is approval for any policy exception sought from the Board?	[ ]Yes [X] No
Does the project include any critical risks rated "substantial" or "high"?	[X]Yes [ ] No
Does the project meet the Regional criteria for readiness for implementation?	[X]Yes [ ] No

Project development objective

Project Development Objective for Phase 1 is to assist the Recipient in addressing immediate constraints to reducing longer-term maternal and under-five mortality.

Project description

Component 1: Phase 1 Local Councils Health Plans ($5.6 million): This component is dedicated to assisting the Recipient in addressing immediate constraints in reducing longer-term maternal and under-five mortality. The activities to be carried out are those included in the LCs' Phase 1 plans and are organized by service delivery mode; family community based care, population oriented services, and clinical care[1]. A fourth sub-component is intended to strengthen capacity for management and monitoring and evaluation at the decentralized levels.

Component 2: Project Management, Monitoring and Evaluation ($0.4 million): This component supports the building of capacity of the IRCBP Coordinating Unit, the LGFD, and the MOHS for the coordination, implementation, monitoring and evaluation of the Project.

Which safeguard policies are triggered, if any?
Environmental Assessment (OP/BP 4.01) is triggered.

[1] This is consistent with the approach endorsed by the Africa Union and described in "A Strategic Framework for Reaching the Millennium Development Goal on Child Survival in Africa: Through Health System Strengthening and implementation at Scale of Integrated Packages of High-Impact and Low-Cost Health and Nutrition Interventions, September 2006.

Significant, non-standard conditions, **if any**,:

Board presentation:
None.

Grant effectiveness:

- Adoption of the Project's Operational Manual.

Covenants applicable to project implementation:

(a) Quarterly progress reports including, procurement, physical performance assessment and financial progress will be prepared and sent to the Bank no later than 45 days from the end of the quarter; and
(b) Final audit report for entire duration of Phase I will be prepared and submitted to the Bank within six months of the end of Phase I.
(c) The Phase 1 plan activities will be carried out pursuant to a sub-grant agreement between GOSL (through the LGFD) and each Local Council.

I. STRATEGIC CONTEXT AND RATIONALE

A. COUNTRY AND SECTOR ISSUES

1. Sierra Leone recently concluded its second round of elections since peace was formally declared in January 2002. The former opposition - the All People's Congress - has captured both the presidency and the parliament. The new president, Ernest Bai Koroma, was sworn into office on September 18, 2007.

2. Economic growth has been strong between 2002 and 2006 with an average annual growth rate of 6.5 percent. Over the same time period inflation has averaged around 10 percent. However, between 2001 and 2006, fiscal revenues covered only half of total expenditures implying a high level of dependency upon external aid. Sierra Leone obtained significant amounts of debt relief by reaching the Heavily Indebted Poor Countries Program Completion Point in December 2006 and expenditures on poverty reduction have increased.

3. With the Local Government Act of 2004, Sierra Leone launched the process of decentralization, transferring functional and fiscal responsibility for key public services from the central government to the nineteen newly elected Local Councils. The initial transition period of 2004 to 2008 focuses primarily on the three sectors—health, education and agriculture—that are most central to poverty reduction and command the largest shares of government expenditures. The Local Government Act 2004 was seen as a way to contribute to consolidated peace in the country as well as improving participatory governance and facilitate the effective and efficient provision of services at the local level.[2]

4. While the provision of basic services has recovered since the civil war (1990-2001), improving outcomes in these sectors remains an enormous challenge. In 2006, the country was ranked second to last in the 2006 United Nations Human Development Index. Roughly 70 percent of the population was below the poverty line in 2004.

5. Part of the reason Sierra Leone's UN Human Development Index rank is so low is because it has some of the worst health outcomes in the world. Among these are the maternal mortality rate, the infant mortality rate, and the under-5 mortality rate. (Table 1) Life expectancy is 41 years and only 8 of 177 countries are worse. The country suffers from diseases for which cost-effective interventions are available including malaria, tuberculosis, acute respiratory diseases, and diarrhea. Fertility rates are high due to low contraceptive utilization and malnutrition is widely spread among children and lactating mothers.

[2] In total there are 19 Local Councils – 13 District Councils, one each in the 12 districts and the Western Rural District. In addition there are 6 city councils, 5 of which are collocated in 5 districts and the Freetown City Council

Table 1: Selected Health Outcome Indicators

	Sierra Leone
Measles immunization rate (% children ages 12-23 months)	67
Maternal mortality rate (per 100,000 live births)	1,077
Infant mortality rate (per 1,000 live births)	165
Under 5 mortality rate (per 1,000)	267
Underweight prevalence	31
Tuberculosis incidence (per 100,000)	475
HIV/AIDS prevalence (% of population ages 15-49)	2
Life expectancy (years)	41

Source: MICS 2005

6. The poor health outcomes are due, in part, to the under use or unavailability of proven cost effective health interventions. The Government of Sierra Leone (GOSL) recently adopted two important health policies: one for reproductive health and another for child health. These policies will form the basis of a new reproductive and child health strategy which is currently under preparation. A key part of this strategy is to scale up a package of key interventions like those listed in Table 2.

Table 2: Selected Health System Performance Indicators (2005)

	Sierra Leone
Under-five children sleeping under ITNs	5.3
Exclusive Breastfeeding for first 5 months	7.4
Antibiotic treatment of Pneumonia	21
Skilled Deliveries	43
Appropriate malaria case management	52
Complementary feeding/Breast feeding continuing for 6-9 months	53
Complementary Feeding/Breastfeeding continuing for 20-23 months	57
Measles vaccination at one year	62
Tetanus Toxoid vaccination for Pregnant women (TT2+)	66
Clean practices at delivery	80
Vit A supplementation for 6-59months children	9

Source: MICS 2005

7. The experience of decentralization of primary health care services has been largely positive. Clinic surveys carried out in 2005 and 2006 as part of the World Bank financed Institutional Reform and Capacity Building Project (IRCBP) showed significant positive changes

in six of eight indicators of clinic quality. National panel data from 2005 and 2007 provides evidence for notable improvements in access to and satisfaction with government health services, maintenance of the same level of birth and death registration, and an increase in the use of government clinics (accompanied by a decrease in the use of district hospitals). Finally, district-level health employees repeatedly emphasize the elimination of bureaucratic delays in accessing resources from Freetown as the most significant contribution of decentralization. Moving budgetary and activity approval to the district level closes the gap between planning and implementation.

8. To alleviate poverty, the Government has protected social sector expenditure in the face of a severe dwindling of revenues. In 2007, nearly 14% of the GOSL budget was for the health sector having increased from 8 percent in 2004 (Table 3). And while revenue collection has been lower than expected in 2007, financing to the LCs for the devolved functions has been protected. LCs currently control 23% of the recurrent health (i.e. not capital investment) expenditures allocated to central and local government and 62% of the expenditures for primary health care.

Table 3: Selected Health Care Financing Indicators

	Sierra Leone
GNI Per Capita 2005 (US$)	220
Health Expenditures 2004 (% of GDP)	3.3
Public Sector Health Expenditures 2004 (% GDP)	1.9
Public Sector Health Expenditures 2004 (% total health expenditures)	59
Recurrent health expenditures 2004 (% of total recurrent)	8.2
Out of pocket 2004 (% of private health expenditures)	100
External Resources 2004 (% total health expenditures)	35
Spending per capita (2004) $	7

9. The recent Situation Analysis of the sector identified some of the following issues:

- Insufficient availability and accessibility to health services: access to health care is constrained by a complex mix of limited availability of staff, drugs and commodities, lack of transport and communications and affordability. There is a critical shortage of skilled health workers, particularly outside Freetown[3]. Staff are de-motivated because of poor pay, poor working conditions and inadequate housing provision. Formal user fees were introduced in 2004, and although services for reproductive and maternal and child health are 'free', there are clearly mixed messages, hidden charges and lack of transparency and financial management. The failed system now requires health workers in the periphery to

[3] For example, of the 15 doctors who qualified in 2005, 10 left Sierra Leone immediately for better job prospects abroad.

travel to the district hospital to collect the drugs for their Perepheral Health Units (PHUs)[4] and the collection of a fee is typically the only way a health worker can recover the cost of transport to and from the district hospital.

- Limited demand for proven high impact interventions: use of health services does not only depend upon their availability and accessibility, but also on whether those services are used by the population. The primary demand side constraints are social and cultural norms and lack of knowledge. Low usage of exclusive breastfeeding is a good example where improved knowledge and acceptance by the society would have a significant impact on U5MR.

- Inadequate access to clean drinking water and suitable sanitation facilities: Overall, 47 percent of the population has access to improved drinking water sources – 84 percent in urban areas and 32 percent in rural areas. Among regions, the situation is best in the largely urban Western Area (87 percent) and worst in the North, where only 30 percent of the population gets its drinking water from an improved source. Thirty percent of the population of Sierra Leone lives in households that use improved sanitation facilities. This percentage is 64 in urban areas and 17 percent in rural areas.

- A weak health information system (HIS): An assessment of the Sierra Leonean health information system was completed in October 2006 with the assistance of the Health Metrics Network (HMN). That assessment identified the following priorities: i) clarification of the national HIS policy and legal framework and to focus more effectively on the implementation of the policy; ii) development of a comprehensive M&E framework for health and harmonization of the health-related indicators of different Ministries, agencies and sectors; iii) capacity building at the sub-national level for data management and analysis; iv) harmonization of the data collection tools for the different public health programs; v) integration and improvements in access to existing statistics; and vi) education of policy makers and senior decision makers about the value and the interpretation of health statistics. It is critical that the MOHS and the LCs as well as community and civil society groups be able to effectively monitor both national and local improvements in health services as well as financial inputs and health outcomes over time.

- Lack of clarity on the relative roles of the DMOs, LCs, and MOHS. The main issue here, which was identified during the mid term review of the IRCBP, is that the structure of DHMTs has not changed vis-à-vis the creation of the LCs. The 2004 decentralization reform divided five of the districts into separate LCs taking into account the main urban areas in the country. However, the number of DMOs has not changed, meaning that five of the DMOs now report to two separate LCs (Table 4). Only one of these – Bonthe District – has prepared two separate 2007 district health plans. The GOSL is aware of the problem and is now assessing how to resolve this issue which is likely to require a change in the law.

[4] The public primary health care system comprise 3 types of peripheral health units – community health centers, community health posts and MCH posts. There are over 900 PHUs in the country (public and private).

Table 4: Mapping of regions, districts, and local councils

Regions	Districts	Local Councils
Northern Region	Koinadugu District	Koinadugu District
	Bombali District	Bombali District
		Makeni City
	Kambia District	Kambia District
	Port Loko District	Port Loko District
	Tonkolili District	Tonkolili District
Southern Region	**Bo District**	Bo District
		Bo City
	Bonthe District	Bonthe District
		Bonthe Municipality
	Moyamba District	Moyamba District
	Pujehun District	Pujehun District
Eastern Region	**Kenema District**	Kenema District
		Kenema City
	Kailahun District	Kailahun District
	Kono District	Kono District
		Koidu/New Sembehun City
Western Region	Western Area Urban District	Freetown City
	Western Area Rural District	Western Area Rural District

Bold indicates Districts with 2 local councils

B. RATIONALE FOR ACGF SUPPORT AND BANK INVOLVEMENT

10. The proposed project was selected as one of the first to be financed by the Africa Catalytic Growth Fund (ACGF). The rationale for ACGF involvement is based on country qualification as a transformational country, innovative strategy to achieve significant results, ability to scale up funding to achieve greater impacts, and country based, multi-sector model to tackle under-five mortality[5].

11. Transformational Country: Sierra Leone has emerged from a decade long civil war that ended in January 2002. Since the end of the conflict, the conduct of macro policy has been conducive to sustained medium-term growth. The Government has a credible strategy for sustained reform, as evidenced by improvements in Country Performance Institutional Assessment ratings (including economic management, structural policy social inclusion and public sector management). Sierra Leone is no longer eligible for IDA post-conflict or Low Income Country Under Stress Trust Fund resources.

[5] ACGF projects must clearly demonstrate: (i) the strategic use of ACGF to scale up impact in a country and contribute to sustained growth or progress in achieving a hard to reach MDG; (ii) the overall outcome based strategy to break the related constraint to growth or to achieve a hard to reach MDG and how the ACGF is positioned to crowd in other donors to meet financing gaps or leverage existing funds to achieve impact; and (iii) the transformational change brought about by the project, and inter alia, the results expected.

12. Innovation and Results: The project will address the hard to achieve MDG for child mortality as well as contribute to the MDGs for maternal mortality and malaria/TB/and HIV/AIDS. By implementing the ACGF project, Sierra Leone would be the first country to follow the Africa Union's published decision to accelerate action for child survival and development in Africa to meet the MDGs (July, 2005). The proposed approach to tackle under-five mortality builds on knowledge of high impact interventions that can be brought to scale through population-oriented services, strengthening of community-level action, and medium term improvements in service delivery modes. The Bank, by showing confidence in the approach, is likely to encourage other donors who are committed to achieving the MDGs to finance Accelerated Child Survival Development programs throughout Africa.

13. Scaling up for Increased Impact. ACGF financing will catalyze additional financing for under-five mortality and maternal mortality, as well as technical support from the United Nations Children Fund (UNICEF) and other United Nations (UN) agencies. Already, the United Kingdom's DfID has committed direct support of US$100 million over ten years, and is in the process of committing to increased funding for the water sector (which will also contribute to under-five mortality reduction). The Health Metrics Network (HMN) approved a $200,000 program in June 2007 to assist in the Health Management Information System. Irish Aid has committed US$1 million for 2007 with the intent to finance the larger program beginning in 2008. Other donors, such as the African Development Bank and Japanese International Cooperative Agency are expected to align their programs to the National Reproductive and Child Health Strategy, which will be developed through ACGF support.

14. Country Model and Multi-sector Approach. The project will take a multi-sector orientation to tackling maternal and child under-five mortality and will help to strengthen both the national health care system as well as decentralization, through its work with the LCs.

15. The project is in line with the Africa Action Plan[6] and the World Bank's new strategy for health, nutrition and population[7] which commits the Bank to focusing on health systems as a key vehicle to improve health outcomes and project populations from the impoverishing impact of illness. It also contributes to the Africa Region's action plan to support capacity development – the CDMAP, specifically with regards goals and outcomes (ii), (iv), and (v) listed below.[8]

16. The Bank has a long history of supporting the health sector in Sierra Leone. Currently the MOHS is implementing the IDA financed Health Sector Reconstruction and Development Project (HSRDP) which focuses on restoring essential health services after the war. The IDA-financed ongoing project on Institutional Reform and Capacity Building Project (IRCBP), which supports decentralization of key services including health, also provides strong justification for

[6] Accelerating Development Outcomes in Africa: Progress and Change in the Africa Action Plan. DC2007-0008
[7] Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results. CODE2007-00016
[8] The Africa Region's action plan to support capacity development – the CDMAP – was launched in July 2006. CDMAP emphasizes delivering results by creating space for learning by doing, supporting domestic accountability mechanisms, and avoiding supply-driven initiatives. It embodies 20 actions focused on five goals and outcomes: (i) more reliable and accountable public financial management systems, (ii) improved capacity for effective delivery of public services, (iii) better and more appropriate skills to support growth and competitiveness, (iv) capacity to deliver essential services in post-conflict countries, and (v) improved capacity for country leadership through more effective management and monitoring for results.

the Bank's involvement. A recent assessment of the first year of decentralization has already shown improvements at the local level in service delivery, transparency, and patient satisfaction.

17. Finally, the Bank's involvement in other key sectors which have significant impact on health such as power, water, and transport, will support greater cross sectoral dialogue and improvements in outcomes.

C. HIGHER LEVEL OBJECTIVES TO WHICH THE PROJECT CONTRIBUTES

18. The country's current Poverty Reduction Strategy Paper (PRSP), whose objectives are set with reference to the MDGs, covers the three year period from 2005-2007. The health related goals and targets for the period 2005-2007 are to: (i) reduce maternal, infant, and under five mortality by one third; (ii) reduce morbidity and mortality due to malaria and other communicable diseases by 50 percent; (iii) reduce the incidence of HIV/AIDS and other sexually transmitted diseases (no target given), and (iv) reduce malnutrition, especially among children and women (no target given).

19. These goals are to be achieved by focusing on ensuring equitable access to affordable basic services and improving quality of service and restructuring the delivery mechanisms, especially for the poor and vulnerable. The GOSL intends to achieve this by providing a country-wide primary health care service package that will focus on maternal, infant and under-five mortality, malaria and communicable diseases, HIV/AIDS and other sexually transmitted diseases. Devolution of health management is an important part of that strategy because it will encourage efficiency, accountability, and community participation.[9]

20. This project contributes to this overall objective by: (i) procuring commodities and medical equipment that are required to implement a country-wide primary health care services package focusing on those which are most cost effective and that will have the largest impact on child mortality; (ii) financing recurrent costs necessary for outreach in order to improve access to essential public health services; (iii) training new cadres of health professionals in order to improve access; and (iv) strengthening the capacity of the DHMT to supervise PHC, including the introduction of a new child survival monitoring system by financing vehicles, training and recurrent costs for these visits.

[9] Government of Sierra Leone, Poverty Reduction Strategy Paper: A National Programme for Food Security, Job Creation, and Good Governance (2005-2007) March 2005.

II. PROJECT DESCRIPTION

A. FINANCING INSTRUMENT

21. The project will be financed by the ACGF and managed as a recipient executed trust fund. A project preparation advance (PPA) trust fund grant of US$1.7 million has already been approved[10] by the ACGF and is being used for the preparation of Phase 2. The Project is proposed to be implemented in two phases.

- Phase 1 is a $6,000,000 grant that will assist the Recipient in addressing immediate constraints to reducing longer-term maternal and under-five mortality and pave the way for implementation of the main ACGF grant. Phase 1 will cover a period of six months.
- Phase 2 of the Project is expected to be presented for approval in March 2008 and effective by July 1, 2008. Phase two will be financed by an ACGF grant of approximately $22,000,000 and will also include the contribution from DfID. This is explained in detail below.

B. PROGRAM OBJECTIVE AND PHASES

22. The Government's Reproductive and Child Health Program is being designed with three separate phases. The overall development objective of the entire program - Phases 1, 2, and 3 - is to reduce the level of under five mortality (currently at 267/1000 live births) and maternal mortality (1,300/100,000 live births).

23. The ACGF would finance the first two phases over a 4-year period.

- Phase 1 will begin around January 1, 2008 and end around June 30, 2008. Phase I objective is to assist the Recipient in addressing immediate constraints to reducing longer-term maternal and under-five mortality.

- Phase 2 will continue to scale up the priority programs and contribute to the 10-year goal of reducing maternal and child mortality. Arrangements in Phase 2 are also likely to be more complex and include pooling funds with other development partners, channeling funds through NGOs and introducing performance based grants to the Local Councils. Phase 2 will have to deal with the very difficult issue of human resources including staff motivation/morale, availability, distribution, etc. Finally, Phase 2 will also focus on water and sanitation and be closely tied to the planned 10-year DfID program in that sector. It is expected that Phase 2 will have a measurable impact on under-five mortality.

- Phase 3 will be implemented from January 1, 2011 to December 31, 2016. The objective of Phase 3 is to continue to reduce the under-five mortality rate (U5MR) and

[10] The PPA is intended to cover preparation costs for the second phase of the program. It focuses on developing a strong M&E system and undertaking necessary background studies to complete a detailed implementation plan for the program.

show measurable reductions in the maternal mortality rate. At this moment, DfID is the only development partner to commit to a ten year program and consequently to finance Phase 3.

C. PROJECT DEVELOPMENT OBJECTIVE AND KEY INDICATORS

24. The Project Development Objective for Phase 1 is to assist the Recipient in addressing immediate constraints to reducing longer-term maternal and under-five mortality.

25. Baselines and targets for each district are in Annex 3. The key performance indicators are with the targets set as minimum values estimated to be achieved by the project closing date, unless otherwise specified:[11]

At least 10 of 13 districts achieve the following targets:

- percentage of pregnant women who make their first Anti Natal Care visit between January 1, 2008 and June 30, 2008 increased by at least 10 percentage points;
- % of infants receiving first dose of penta vaccine between January 1, 2008 and June 30, 2008 increases by at least 10 percentage points;
- 80% of PHU staff targeted for training in the Phase 1 health plan are trained;
- 80% of Community Volunteers targeted for training in the Phase 1 health plans are trained;
- 90% of PHUs are visited by the DHMT between April 1, 2008 and June 30, 2008; and
- 90% of Integrated Child Survival forms are submitted by the PHUs to the DHMT within 15 days of each month for the three months period beginning on April 1, 2008.

26. Phase 1 outputs are the first step in a results chain which would then go on to influence behavior (sensitization meetings), improve access (outreach clinics), and improve quality (supervisory visits to PHUs) and ultimately lead to improved health outcomes. In other words, it is that Phase 1 will put in place the necessary inputs for Phase 2 such as transportation, drugs, ITNs, additional training for personnel, equipment packages for midwives, etc. Completion of Phase 1 allows Phase 2 to start providing services immediately. Therefore the performance indicators are meant to assess the capacity of the DHMT to scale up and their readiness to begin Phase 2.

[11] These types of indicators were selected because it is similar to what is used in the IRCBP where at least 14 of the 19 councils must achieve their targets.

D. PROJECT COMPONENTS

Component 1: Phase 1 Local Council Health Plans ($5.6 million)

27. Component 1 is dedicated to implementing the Phase 1 District Health Plans which are based upon scaled up activity from the 2007 plans. Support will be provided through sub-grant agreements with each Local Council (Annex 15) for the financing of activities specified in the Phase 1 health plans approved by the LCs, MOHS, and the Bank (available in the Project files).

28. The activities identified in the scaled up plans are organized by service delivery mode: family community based care, population oriented services, and clinical care.[12] A fourth sub-component is intended to strengthen capacity for management and monitoring and evaluation.

29. Delivery Mode 1: Family and Community Based Care. These are services that can be delivered by the community following training from health professionals. The project will finance goods, medical supplies, training, IEC, and operating costs in order to scale up the following interventions:

- prevention of malaria using ITNs for pregnant women and infants;
- promotion of hand washing by mothers;
- chlorination of wells to ensure access to safe water;
- improved neonatal care by ensuring clean delivery and cord care;
- promotion of early, exclusive, and prolonged breastfeeding;
- promotion of use of ORS for diarrhea;
- community based treatment of children with malaria with artemesinin based combination therapy; and
- vitamin A treatment for measles.

30. Delivery Mode 2: Population Oriented Services. These are schedulable services provided through regular outreach sessions. This mode of delivery is particularly important for remote areas with limited access to PHUs. This sub-component will finance transport for outreach (bicycles, motorbikes, boats, and vehicles), medical supplies, training, and IEC in order to carry out the following interventions:

- preventive pregnancy care which includes antenatal care, situational IPT for malaria, and tetanus immunization
- preventive infant and child care which includes provision of measles immunization, DPT3, and Vitamin A

31. Delivery Mode 3: Clinical Care. These services are delivered at PHUs with the presence of skilled health professionals. To achieve the U5MR MDG, it is necessary to have skilled attendance at childbirth and obstetrical emergencies, and appropriate management of neonatal

[12] This is consistent with the approach endorsed by the Africa Union and described in "A Strategic Framework for Reaching the Millennium Development Goal on Child Survival in Africa: Through Health System Strengthening and implementation at Scale of Integrated Packages of High-Impact and Low-Cost Health and Nutrition Interventions, September 2006.

distress and acute and serious childhood illnesses. The project will finance goods, medical supplies, training, treatment protocols, IEC, and operating costs in order to:

- Ensure skilled care deliveries by training PHU and hospital staff
- Ensure that PHUs are able to provide basic emergency obstetric and immediate neonatal care (B-EONC)

32. Capacity Building, and Monitoring and Evaluation. The objective of this sub-component is to support capacity building for the DHMT and ensure that the new Monitoring and Evaluation system is functioning properly. It will finance training, office equipment and supplies, technical assistance, and incremental operating costs.

Component 2: Project Management, Monitoring, and Evaluation ($0.4 million)

33. This component supports the building of capacity of the IRCBP Coordinating Unit, the LGFD, and the MOHS, for the coordination, implementation, monitoring and evaluation of the Project through the provision of technical advisory services, equipment, vehicles, operating costs and training.

E. Lessons Learned and Reflected in the Project Design

34. Project design focuses on the selection of evidence-based interventions that have been identified over the last couple of years and documented in various scientific journals such as the Lancet and the British Medical Journal. Experience shows that some of these high-impact interventions can be brought to scale more easily than others under existing institutional and system limitations because the obstacles to their scaling-up can be addressed relatively quickly through schedulable, population-oriented services and strengthening of community-level action. The MBB exercise helps to estimate the impact of different interventions by taking into account not only their proven cost effectiveness but also by controlling for country specific parameters such as human resources, logistics, etc ... One lesson that has been learned is that predicted impact of these interventions can be estimated taking into account different country circumstances.

35. Obstacles to a comprehensive implementation of the continuum of care concept, across service delivery modes and age groups, need to be addressed over the medium term – acknowledging that the process requires time and financial resources.

36. It is worth noting that sexual, reproductive and child health are inextricably linked. Globally, 40 percent of all child deaths occur within the first month of life, and up to 70 percent of these could be prevented through improved maternal health services[13]. A maternal death has a massive negative impact on the health, well-being and access to education of young and older children as well as on household livelihoods. Consequently the project contains interventions aimed towards pregnant women but which have a large potential impact on U5MR.

[13] McDonagh, S (2003) 'Maximising synergies between maternal and newborn health, Options/DfID.

F. ALTERNATIVES CONSIDERED AND REASONS FOR REJECTION

37. A variety of options were discussed on the operation. The use of IDA funds was not an option, as all funds had already been committed in the CAS of May 5, 2005, and the next CAS was not scheduled until FY10. The ACGF was the only funding mechanism available for the operation.

38. The team considered delaying implementation until 2008, when a broader strategy for maternal and child mortality with additional DfID funding would be ready. The other option for scaling up the immediate needs in the district health plans was to use the project preparation advance (PPA). However, for fiduciary reasons, the preparation advance would need to separately cover activities directly related to preparation of the project, as opposed to implementation of project start-up activities. A preparation advance was approved in April 2007 for $1.7 million for preparatory activities for Phase 2, including strengthening M&E, holding workshops, and conducting necessary studies including in health care financing, human resources, social assessment and institutional assessment.

39. Another option considered was that of processing an additional financing to the IRCBP. From a process viewpoint, Phase 1 could easily have been designed as a supplemental to the IRCBP. However, the team felt that the process itself would not be simpler than preparing a separate project and also, it seemed appropriate to use an APL approach where linkages between Phase 1 and Phase 2 are explicit.

40. As such, the team proposed an innovative approach, similar to a hybrid APL, which would allow alignment with DfID funding and the broader strategy while also assisting the Recipient in addressing immediate constraints to reducing longer-term maternal and under-five mortality. The team felt this addressed the Quality at Entry Report's concern that project preparation should be aligned and harmonized with DfID, while also enabling the immediate scaling up of priority programs in the district health plans. Following extensive discussions at the Bank, with other Development Partners, and with the GOSL, it was decided to pursue this APL approach.

41. This decision resulted in the division of the ACGF's contribution into two Phases covering 4 years, from December 1, 2007 to end 2011. Phase 1 would last for six months beginning on or around December 1, 2007. While in theory there would be an overlap between Phases 1 and 2, it is likely that final approval of the country's Reproductive and Child Health Strategy as well as completion of a harmonized program of support from the World Bank, DfID, Irish Aid, and other donors may not be agreed upon before the start of the program in 2008. Extending Phase 1 into 2008 will ensure that the program can "start" even if a PAD for Phase 2 has not been completed and approved by the end of 2007.

III. IMPLEMENTATION

A. PARTNERSHIP ARRANGEMENTS

42. Phase 1 is being prepared with the participation of all key development partners. Phase 2 is likely to have more complex arrangements where partners will agree to the GOSL's Reproductive and Child Health Policy and pool their funds to support. These options are being discussed as part of preparation for Phase 2.

B. INSTITUTIONAL AND IMPLEMENTATION ARRANGEMENTS

43. The Phase 1 project builds on on-going activities that are being implemented by the Local Councils (LC) and district health management teams (DHMT). See Annex 6 for more details.

44. Each LC has an annual health development plan that is prepared and reviewed by the DHMT and approved by both the local council and the MOHS. In scaling up the plans, the following criteria were used in determining what could be considered eligible for financing under Phase 1:

- Has already been included in the original 2007 annual LC plan
- Is of proven high impact and cost effective in contributing to reducing child mortality
- Expresses a clear link from activity to output to outcome

45. This supports the on-going decentralization process in Sierra Leone, which the World Bank is supporting through an ongoing project (IRCBP). Through this process, local councils are already managing both Government and World Bank financing, and the phase 1 ACGF grant would be an additional source of funding for the country's health program at the local council level. The flow of funds and financial management of the new grant will follow the procedures established for the IRCBP and in particular for the "local government development grants" facility financed through the IRCBP (Annex 7).

46. Technical Implementation: The MOHS will have technical responsibilities for the Project in the same manner as for the IDA-financed ongoing Health Sector Reconstruction and Development Project. As such, the Director General of Medical Services will be responsible for project technical implementation. The Director of Planning and Information will ensure coordination between the Local Government Finance Department (LGFD), established within the MOF, and the MOHS and development partners. All other top management teams of the ministry will continue to coordinate the scaled-up activities as they do under the HSRDP. A variety of actors at different organizational levels, including the District Health Management Teams (DHMT) and technical program managers at the national level, will be responsible for implementation of activities according to their comparative advantage.

47. Fiduciary Management and Implementation. While the MOHS will ensure technical quality of the implementation of Local Councils' District Health Plans, the Local Government

Finance Department (LGFD) of the Ministry of Finance will monitor as for the IRCBP, the financial and physical performance of the LCs in the development of services and their capacity to deliver. The IRCBP Coordination Unit will ensure the day-to-day fiduciary responsibilities for the Project and will liaise with the MOHS for technical inputs. The LGFD will prepare quarterly project interim reports (IFR) in the areas of finance, procurement, including complaints from bidders, and project progress. The financial management system put in place will be capable of producing these reports.

C. MONITORING AND EVALUATION OF OUTCOMES/RESULTS

48. The MOHS, with the assistance of the Health Metrics Network, has prepared a Performance Monitoring Plan that aims to optimize the performance of health service providers at all levels of administration through the provision of necessary and sufficient information needed by policy planners and decision makers, and health managers to plan, monitor and evaluate the activities conducted under the Reproductive and Child Health Program. (Annex 3)

49. The tools that have already been developed will be used to monitor Phase 1 and include:

- Monthly Integrated Child Survival Forms that are filled out by health facilities and provided to the Districts who enter the information into a database and produce reports that are forwarded to the national level of compilation, analysis, and dissemination. The child health component collects information on immunization, bed net usage, nutritional status, and prevalence and management of the three main killers of children in Sierra Leone – malaria, acute respiratory infections and diarrhea.

- Integrated District-Level Supervisory Visit to Health Facilities: All DHMTs are expected to visit all their PHUs every quarter. PHU supervision is done using a new PHU checklist that has been entered into PDAs. At the end of each round of supervision, the data in the PDAs are downloaded and analyzed.

- Health Facility Quarterly Supervision Report: Independent of the DHMT supervision of PHUs, the Director of Policy and Information (DPI) also conducts quarterly supervision reports in about 10-15% of the PHUs in each district. During these visits, the DPI uses a structured supervision checklist. The checklist included key observable features that are considered to be critical to health care delivery.

50. In-service training of existing staff has been provided for training of service providers at the facility level, training of current M&E officers at the district level, and training of the staff of the MOHS. Phase 2 will introduce a more skilled cadre to support data management at the district level and will also focus on recruitment and retention of additional health information specialists. This will be described more fully in the PAD for Phase 2.

D. SUSTAINABILITY

51. The government of Sierra Leone has demonstrated a strong and long term commitment to improving the health status of the population through initiatives such as the PRSP, decentralization, and anticorruption legislation within the government. The midterm review of the IRCBP confirmed that LCs have the capacity to implement Phase 1 and necessary training will be provided during Phase 1 in order to ensure adequate implementation for Phase 2.

52. The financial sustainability of the project is high given the planned Phase 2 financing from the ACGF. Although financing from the ACGF will extend only until end 2011, it is likely that the long term commitment of DfID will encourage other partners to continue funding the sector. An analysis of fiscal space will be undertaken in 2007 to help plan for Phases 2 and 3 and a new health care financing strategy is under preparation.

E. CRITICAL RISKS AND POSSIBLE CONTROVERSIAL ASPECTS

Risk	Risk Rating	Risk Mitigation Measure
From Outputs to Objective		
Change of ruling party in August 2007 may result in loss of ownership and commitment or slow down of preparation due to likely parliament changes	High	Ensure that ownership and commitment are de-linked from political changes by engaging a wide group of stakeholders. The manifestos of the three main political parties are consistent in their support to decentralization and priority given to MCH.
Preparation of the national Reproductive and Child Health Strategy (Phase 2) is delayed	Moderate	Hire additional management team to help prepare. Work with GOSL to finalize study TORs.
Cross sectoral implementation is not sufficiently coordinated	Moderate	The National Health Policy Advisory Committee (NHPAC) will ensure broad-based, inter-sectoral participation and coordination, supported by the Steering Committee for Child, Reproductive and Sexual Health, and the Health Task Force.
From Components to Outputs		
LCs underestimate the time or activities necessary to achieve intermediate results from completion of activities	Moderate	IRCBP and MOHS to provide support during planning and implementation.
Inconsistent practices at the local level make the aggregation and use of data difficult	Moderate	Data collection will be part of the ongoing M&E for the IRCBP which ensures that data are consistent across LCs.
Insufficient local capacity to implement activities requested for funding	Moderate	Assessment of the feasibility of implementing activities requested for funding during the planning stage.
Overall Risk Rating	**Moderate**	

F. LOAN/CREDIT CONDITIONS AND COVENANTS

53. Effectiveness conditions

- Adoption of the Project's Operational Manual

54. Legal and Financial covenants

- Quarterly progress reports including procurement, physical and financial progress will be prepared and sent to the Bank no later than 45 days from the end of the quarter.
- A final audit report will be prepared for the entire duration of the phase 1 project and submitted to the Bank within six months of the end of Phase 1.
- The 2007 LCs' health plan activities will be carried out pursuant to a sub-grant agreement between GOSL (through the LGFD) and each Local Council.

IV. APPRAISAL SUMMARY

A. ECONOMIC AND FINANCIAL ANALYSES

55. The project, by definition, is based on scaling up a set of interventions that have proven to be cost effective in a variety of studies. Annex 9 provides a more detailed explanation of the cost effectiveness of each intervention and the possible impact on the U5MR.

56. The project will increase the LC 2007 budget allocation for health by approximately 20% or an additional US$1 per each child under the age of 5. While this may be a modest increase, sustainability of any additional financing for the sector is a risk and one of the reasons that development partners have agreed to finance a 10-year program.

B. TECHNICAL

57. The project supports implementation of a set of evidence-based health interventions with proven efficacy on maternal and child health. Recent scientific research provides increasingly solid evidence of how, and to what extent, specific health interventions can improve health outcomes. This research includes Lancet Child Survival and Neonatal series, the Cochrane review on the health interventions targeting maternal mortality and the British Medical Journal publications several international sources. These "high impact interventions" can be integrated into various service delivery arrangements already in place in a given country and be brought to scale more easily than others under existing institutional and system limitations because the obstacles to their scaling-up can be addressed relatively quickly.

58. Under the overall leadership of UNICEF, accelerated maternal and child survival programs have already been introduced in districts in eleven countries in West and Central Africa. Results suggest that between 2002 and 2004, increased coverage of a package of selected high-impact interventions in demonstration districts in Senegal, Mali, Benin and Ghana reduced the under-five mortality rate by 20% on average.

C. FIDUCIARY

59. The established mechanisms under the IRCBP will be used including financial management arrangements used to approve and allocate resources to the councils. The advantages of this option include: i) collaboration and use of established systems of another Bank funded project (IRCBP) and ii) help for the decentralization process through assistance to the local councils as they implement devolved services. The disadvantage will be expected delays in the implementation process as it involves the local councils with weak capacities.

60. The Government has also introduced a number of proactive reforms in public financial management including public procurement reforms meant to reduce the opportunities for corruption. The implementation of the public procurement law enacted in 2004 is part of the public financial management reforms component of the IRCBP. The public procurement act is comprehensive and covers all procurement in the public sector including the Local Councils (i.e. city and district councils) which will have procurement responsibility under this project. The established mechanisms under the IRCBP, which have been found satisfactory to the Bank, will guide the procurement process. The procurement capacity of the city and district councils is being enhanced with the recruitment and training of procurement focal persons (with at least a first degree) for each council. The risk is therefore moderate since the bulk of the procurement under this phase 1 will be carried out at the IRCBP procurement unit in collaboration with the MOHS procurement unit.

D. SOCIAL

61. A recent report from the evaluation unit of the IRCBP concludes that the impact of decentralization on primary health care has been positive on a number of dimensions such as quality of services, status of infrastructure, and availability of staff.[14] While this suggests that decentralization has not had a negative social impact, there is still a need to undertake a social assessment that looks particularly at the package of services that are being offered. This is being done under the PPA and will be used in the preparation of Phase 2.

E. ENVIRONMENT

[14] Primary Healthcare in Sierra Leone: Clinic Resources and Perceptions after One Year of Decentralization. June 2007. IRCBP Evaluations Unit,

62. This project, which is expected to support health care service delivery and capacity building, will be implemented in all 13 districts in Sierra Leone through the local council machinery. Although no construction work is anticipated, OP/BP 4.01 is triggered because of the medical waste coming from the use of insecticide treated nets (ITNs) and essential drugs. The Project is using the updated Environmental Management Plan of the recently approved Additional Financing for the Health Sector Reconstruction and Development Project, which was submitted to the Bank and disclosed in-country on October 1, 2007, and submitted to the World Bank's Infoshop on October 1, 2007.

F. SAFEGUARD POLICIES

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP 4.01)	[X]	[ ]
Natural Habitats (OP/BP 4.04)	[ ]	[X]
Pest Management (OP 4.09)	[ ]	[X]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[ ]	[X]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[X]
Indigenous Peoples (OP/BP 4.10)	[ ]	[X]
Forests (OP/BP 4.36)	[ ]	[X]
Safety of Dams (OP/BP 4.37)	[ ]	[X]
Projects in Disputed Areas (OP/BP 7.60)*	[ ]	[X]
Projects on International Waterways (OP/BP 7.50)	[ ]	[X]

G. POLICY EXCEPTIONS AND READINESS

63. There are no policy exceptions.

The project is ready to begin implementation immediately upon effectiveness. The following are in place:

- Phase 1 plans have been prepared, costed, and technically appraised for each council. These plans have been approved by both the MOHS and the individual LC.
- Each council has prepared a training plan which has been approved by the MOHS. Care has been taken to ensure that the plans are realistic and not overly taxing for the sector's limited human resources.
- The project procurement plan has been completed and reviewed by the team's procurement specialist. Bids for supply of vehicles were opened on September 20, 2007.

* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

Procurement documents for other requirements such as drugs and hospital equipment are being prepared for IDA review by end December, 2007[W1].

- A project operational manual has been drafted drawing upon the existing project operating manuals of the IRCBP and HSRDP. Adoption of this manual is a condition of effectiveness.

ANNEX 1: COUNTRY AND SECTOR BACKGROUND

SIERRA LEONE: Reproductive and Child Health Project

A. Country Background

1. Sierra Leone endured a civil war from 1991 to 2002 that led to virtual collapse of social services and economic activities in most parts of the country. As a result, it has found itself among the countries with the worst UNDP development index indicators[15]. After cessation of hostilities in 2002, the government, the UN system, donors and NGOs together embarked on a series of national recovery and reconstruction initiatives. These have steadily restored functional government machinery and social services in all districts; and the mode of operations has changed from national recovery to development with the completion of the government's Poverty Reduction Strategy Paper (PRSP) in 2004.

2. A national census conducted in 2004 reported the country's population to be about 5 million with a growth rate of 1.8 percent, a decline from the 2.3 percent recorded in the 1984 Census. This slow down in population could be due to deaths and emigration caused by the conflict. The total fertility rate, however, remains high at 6.5. There are about twenty (20) ethnic groups in country and the official language is English. Rich agricultural land, minerals, and off-shore fishing indicate that the country has a huge potential in terms of natural resources for its human and socio-economic development, which are important determinants of the health of a population. The adult literacy rates[16] for males and females are estimated to be about 40 percent and 21 percent, respectively. The educational sector, however, is showing some improvement with the introduction of several initiatives such as the Rehabilitation of Basic Education Project started in 2003. The net primary school enrollment rate has increased from 42 percent in 2000 to 69 percent in 2005[17].

3. Although some progress has been made since the end of the war, health status indicators have worsened. Life expectancy has dropped from 42 years in 1990 to 34.5 years in 2001. The provisional results of the 2005 Multiple Indicator Cluster Survey (MICS3)[18] showed that the infant and under-five child mortality rates have not changed from the 2000 MICS2[19] results which remain at an unacceptably high levels of 170 and 267 per 1000 live-births, respectively.

B. Current and Future Economic Conditions

4. Since the end of the civil war, the country's economic performance has been robust, especially during 2002-04, due to a recovery in agriculture and mining outputs, and the country has sustained a strong economic recovery: 4.3 percent Gross Domestic Product (GDP) growth in 2002, 9.3 percent in 2003, and 7.4 percent in 2004. Recovery has been propelled by large-scale resettlement and reconstruction, increases in land under cultivation, a resumption bounce-back in the private sector, and the growth of donor-financed imports.

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[16] UNDP World Development Index Report, 2005.
[17] UNICEF: The State of the World's Children, 2006.
[18] GOSL/UNICEF: MICS 2 &3 reports, 2000 and 2005.
[19] GOSL/UINCEF: Provisional Results MICS3, 2005.
[20] GOSL/UNICEF: MICS2, 2005.

According to the 2003/04 household survey, agriculture, forestry and fishing sustains about 77 percent of the population, but is limited mainly to subsistence farming (mainly rice).

5. While future growth is projected to slow down, macroeconomic performance is expected to remain strong. The average real GDP growth rate is forecast to start out at 7.4 percent in 2006 and gradually taper off to 6.1 percent by 2008. But this is still strong by international standards since even 5 percent per annum could be considered healthy. Much of the growth improvement is expected to come from the resumption of rutile and bauxite operations in 2006, allowing exports to expand by almost 4 percentage points of GDP in that year. Ongoing reforms in the critical mining sector are intended to increase transparency and forestall opportunities for conflict.

C. Governance

6. As a small post-conflict state, Sierra Leone is making real but still fragile progress towards good governance and low corruption. So far no Country Procurement Assessment Report has been issued for Sierra Leone. However, in June 2003, the Bank prepared an Issues Paper on Public Procurement. The assessment rated public procurement practices as poor and not contributing effectively to value for money. The Government has introduced a number of proactive reforms in public financial management, including Public procurement, that are meant to reduce the opportunities for corruption. The implementation of the public procurement law enacted in 2004 is part of the public financial management reforms component of IRCBP. Progress is being monitored under the multi donor budget support program for Sierra Leone. It is expected that the implementation of the procurement reform will reduce opportunities for corruption and improve the efficiency of public spending through fair, open competition.

7. In addition to the monitoring of transfers to the local councils for the health sector under the IRCBP, the other source of information on governance in the health sectors is the annual public expenditure tracking survey. Finally, user fees are allowed in Sierra Leone which generally helps to reduce the level of unofficial payments. The GOSL has recently mandated that the user fees be returned to the treasury and included in the budget. [20]

8. In summary, while there are some very real governance risks, the authorities have been making tangible progress that should be supported and deepened. Government and the key budget support donors have agreed on a well defined program of governance reforms backed by a harmonized approach to reform and monitoring. These reforms and other measures will help reduce the currently high fiduciary risks faced by the donor community.

[20] Charging for health services is controversial within the international community and an issue which will be further analyzed in the health care financing study currently under preparation. It is worth noting that the beneficiaries of this project – children under the age of five and pregnant women – are exempt from these fees.

D. Health Status

9. The provisional results of the 2005 Multiple Indicator Cluster Survey (MICS3)[21] showed that the infant and under-five child mortality rates have not changed from the 2000 MICS2[22] results which remain at unacceptably high levels of 170 and 267 per 1000 live-births respectively, with marked regional and rural–urban variation. The maternal mortality is also among the highest in the world and is estimated at 1,800 per 100,000 live-births.

10. The poor health and nutrition indicators of the country can be attributed to a high disease burden. Malaria (35.1 percent), acute respiratory infection (21.7 percent) and watery & bloody diarrhea (8.1 percent) are the foremost causes of outpatient attendance[23], together accounting for about 65 percent. As well, these three diseases together with malnutrition account for about 75 percent of under – five consultations[24] comparable to reports of the Lancet series. Although the under-five are about 17 – 20 percent of the population they make up 49 percent of consultations at PHUs.

11. Malaria is hyper-endemic/holo-endemic in the country, and affects the whole population, but children under five years and pregnant women are most vulnerable, with high morbidity and mortality. Malaria alone accounts for 33 percent of the under- five mortality. Malaria related anemia is also a major health problem among an already vulnerable population, where children under five and pregnant women are at the greatest risk. Several misconceptions regarding the cause, prevention measures, and treatments contribute to the escalating prevalence. It is then further compounded by a lack of health facilities and extreme poverty. Therefore access to treatment is cut off both financially and locally.

12. The nutritional status of the population is equally poor. Moderate and severe stunting prevalence in under-fives[1,2] increased from 34 percent and 16 percent in 2000 to 40 percent and 20 percent in 2005 respectively. Iodine deficiency disorders are still a public health problem even though there has been significant improvement of goiter and iodine deficiency prevalence rates from 25 percent and 97 percent in 1992 to 3 percent and 33.5 percent in 2003 respectively. The 1998 micronutrient survey reported 40 percent of vitamin A deficiency prevalence among children below five years; and 86 percent anemia among pregnant women.

13. Malnutrition decreases immune system function and the ability to fight infection and disease is compromised increasing the risk of premature death. There is a clear link between malnutrition and child mortality, as malnutrition is a contributory factor in 40 percent of all under-five child deaths[25]. In Sierra Leone, child malnutrition starts very early in life due to sup-optimal infant feeding practices. Many infants are given water, fluids and foods rather than the recommended breast feeding practices. This is very harmful as it exposes infants to pathogens and increases the risk of malnutrition and death. Many children are not fed any complementary foods and therefore lack nutrients essential for survival, growth and development. By age 2 most of the damage to the child's health, growth and development is

[21] GOSL/UINCEF: Provisional Results MICS3, 2005
[22] GOSL/UNICEF: MICS2, 2005
[23] MOHS Morbidity Statistics, 2005
[24] GOSL/UNICEF: Government of Sierra Leone/UNICEF Country Programme 2004-2007
[25] M Aguayo et al, 2003 *Sierra Leone – investing in nutrition to reduce poverty*, Public Health Nutrition 6(7), 653-657

done, and the chances of recovery are minimal[26]. Malnutrition has a devastating impact on learning ability, school performance, and adulthood productivity rates.

Table 1: Health Sector Performance in Selected Interventions in 2005
Comparison to Targets

Intervention	2005 Performance (%)	Target
Under-five children sleeping under ITNs	5.3	75
Exclusive Breastfeeding for first 5 months	7.4	30
Antibiotic treatment of Pneumonia	21	90
Skilled Deliveries	43	60
Appropriate malaria case management	52	60
Complementary feeding/Breast feeding continuing for 6-9 months	53	90
Complementary Feeding/Breastfeeding continuing for 20-23 months	57	90
Measles vaccination at one year	62	70
Tetanus Toxoid vaccination for Pregnant women (TT2+)	66	90
Clean practices at delivery	80	90
Vitamin A supplementation for 6-59months children	9	9

14. Sierra Leone has a young population with 44% under 15 years of age and 51% between the age of 15 and 64 years. The Total Fertility Rate estimated at 5.9 (2000) is high as a result of insufficient use of contraceptives, particularly in the rural areas. Decade of protracted civil war has aggravated the HIV/AIDS pandemic. Results from a 2004 UN-financed sentinel surveillance conducted among 1970 pregnant women revealed a national HIV prevalence rate of 3.4%, of which 4.7% is in Freetown, and 1.7% in the provinces. In 2003, it was estimated that over 100,000 people in the country are living with HIV/AIDS. Compared with neighbouring countries, the HIV/AIDS epidemic is more significant, with a prevalence rate of HIV sero-positivity estimated at about 4.9%. That rate may be as high as 18% in some groups, such as the armed forces (2002 Baseline Survey). The poor health delivery system is in part responsible for the high maternal and infant mortality rates and the rapid re-emergence of tuberculosis, typhoid and cholera. As a result of war atrocities, the country is left with thousands of emotionally and psychologically affected people (mostly women among whom many were raped and/or lost their children and families); and children who are orphaned or living away from their parents.

[26] M Aguayo et al, 2003 *Sierra Leone – investing in nutrition to reduce poverty*, Public Health Nutrition 6(7), 653-657

National District Level Indicators - 2005

Indicators	National	DISTRICTS													
		Kailahun	Kenema	Kono	Bombali	Kambia	Koinadugu	Port Loko	Tonkolili	Bo	Bonthe	Moyamba	Pujehun	Western Rural	Western Urban
Exclusive Breastfeeding Prevalence at 5 months of age (%)	5.5	6.4	11.5	6.6	14.5	12.5	34.5	0.0	9.0	1.5	0.0	4.4	3.8	0.0	2.8
Iodised salt consuption (%)	44.6	71.2	35.3	76.4	63.3	2.8	37.4	20.4	79.9	58.1	12.2	23.9	29.7	15.2	38.4
% of live births below 2500g	23.5	24.1	25.3	19.2	27.9	18.6	20.7	25.9	25.0	22.8	32.2	22.9	21.1	20.2	21.3
DPT3 Coverage among 12-23 months (%)	62.7	25.4	70.7	76.4	76.8	52.4	58.6	50.3	62.2	74.1	71.4	52.6	77.2	37.5	68.8
Fully immunised children (12-23 months) (%)	53.7	18.2	63.4	61.1	71.1	38.1	53.9	47.9	52.3	65.2	60.0	33.3	71.9	12.5	57.1
% of new born protect against Tetanus	77.6	83.3	85.7	88.4	71.9	69.1	71.7	54.0	79.8	87.3	41.9	78.3	88.7	87.7	87.0
Improved source of drinking water (%)	46.5	49.4	70.2	32.9	51.2	22.2	28.7	24.6	19.5	66.8	25.7	19.5	48.7	66.3	88.4
Sanitatary means of excreta disposal (%)	30.5	7.8	40.7	7.4	32.8	19.5	9.5	30.6	10.2	47.0	24.2	9.9	33.5	49.1	72.4
% Contraceptive use	5.3	4.7	4.3	2.4	5.6	1.6	1.1	8.4	2.5	2.7	3.6	1.4	0.6	26.7	19.7
% of women who sought antenal care from a skilled provided	81.1	87.2	87.4	82.9	69.2	84.6	76.5	58.3	84.6	91.6	55.5	76.8	96.1	81.5	93.8
% Skilled dilevery (exclusing TBAs)	43.2	85.5	65.9	52.4	34.8	22.1	25.7	27.6	14.2	50.8	14.5	27.0	45.6	63.1	84.7
% Facility delivery	18.6	16.8	28.5	31.1	18.3	4.7	15.3	16.4	11.2	15.9	12.4	12.3	19.1	19.1	35.6
% of under-fives sleeping under ITNs	78%	86%	-	-	-	82%	88%	67%	71%	82%	79%	-	-	71%	
% of pregnant women sleeping under ITNs	62%	81.7	-	-	-	64.70%	66.0%	53.5%	45.2%	65.80%	75.80%	-	-	48%	
% of population living within 5km from a health facility	77%	64%	76%	78%	80%	74%	33%	82%	67%	82%	67%	69%	67%	95%	100%

E. Health Policy

15. Against this background, the Government is resolved to improve the health status of the people of Sierra Leone by articulating a National Health Policy. The policy provides the framework for the strategic delivery of health services while recognizing the effects of other sectors such as housing, food security, water and sanitation on health. It focuses on the development of preventive, curative and rehabilitative services, and the setting up of health manpower training institutions and strategies to provide a constant supply and retention of all categories of manpower needed to deliver quality health care to all Sierra Leoneans.

16. The goals of the 2002 National Health Policy are to: decentralize the administrative structure of the health care delivery system, culminating in the creation of district health boards which will only function within the framework of less stringent central control; identify areas of possible mobilization of resources to ensure sustainability; provide adequate manpower both in numbers and quality for the effective delivery of health care services to the country with particular emphasis on the rural population; reduce mortality and morbidity among mothers and children; encourage private public partnership; develop optimum use of essential drugs and supplies; reduce the incidence of communicable diseases; improve nutritional status of the population (especially children, mothers and vulnerable groups); train appropriate cadres of health personnel to meet the health needs of the country; and develop and use traditional medicine and other acceptable curative systems.

17. In pursuit of the above, the health sector has adopted primary health care as the strategy to re-vitalize the national health systems with a special focus on the restoration of equity, promotion of rational use of resources, assurance of reliable quality health care and promotion of preventive measures. Given the enormous challenges facing the health sector, the Government of Sierra Leone is responding to the threats and opportunities for action through comprehensive and coordinated initiatives of all stakeholders at central and district levels. The overall goal is to reduce maternal and infant mortality, prevent sexually transmitted infections and reduce the risks of HIV/AIDS transmission, alleviate poverty and enhance family life and national security. It focuses on health systems, human resource development, essential public health and clinical packages, health financing, decentralization, monitoring and evaluation of health interventions as well as partnership for national health development. The PRSP, the Health Sector's Three Year Rolling Plan (2005/07), and the MDGs also advocate priorities and strategies to reduce poverty through improved access and affordability to health care and to reduce maternal, infant and under-five mortality.

18. In response to the major problems facing the health sector and to operationalize the Health Policy, the Government developed a Health Sector Three Year Rolling Plan (2005- 07). It is based on the health sector's major goal, which aims to reduce morbidity and mortality rates, especially among the high-risk groups. Its objectives include delivery of quality, efficient and equitable primary health care to the population, especially those living below the absolute poverty line particularly in the rural areas.

19. Key medium term priorities of the Health Sector's Plan as well as the Government's PRSP focus on improving the delivery and quality of the health care system through greater effective decentralization and partnerships between the public and private sectors; greater

transparency and increased opportunities for community participation; increasing the accessibility and affordability of service delivery through the rehabilitation, construction and re-equipping of a network of health facilities at the primary, secondary and tertiary levels; improving access of basic health services for the poor; reducing maternal, infant and under five mortality by increasing EPI coverage; support to MCH Program; and increasing the availability of trained midwives and access to skilled TBAs as well as the promoting and strengthening of Family Planning activities.

20. As the country progressed from post war emergency planning to long term development planning, the Ministry of Health and Sanitation has developed Reproductive and Child Health Policies that form the basis for the development of a strategic plan for Reproductive and Child Health. The next step will be the development of a National Health Sector Strategic Plan (NHSSP) that will provide the framework for the future development of the health sector.

21. In 2006, the Ministry of Health and Sanitation (MOHS) conducted a situation analysis of women and children in Sierra Leone. Based on the recommendations of the situation analysis, a work plan was formulated to draw a road map for developing the Reproductive and Child Health Policy and the Strategic Plan. To oversee the process of developing the policies and strategic plan, a National Health Policy Advisory Committee (NHPAC) was formed while a National Steering Committee for Sexual, Reproductive and Child Health (NSCSRCH) was established to guide the development of the Strategic Plan and report to the NHPAC.

22. The NSCSRCH, with multisectoral stakeholder representatives, formulated the draft outline of the Strategic Plan in a participatory consultative process and provided opportunity to all stakeholders to participate in formulation of the program. Besides reviewing relevant documents, different programs and options, the participatory strategy development process has been envisaged to consult with key informants, stakeholders of different origins and regions. While the task of extensive review and pursuing participatory process is daunting, it is essential that all stakeholders become owners of the strategy. In this process, the MOHS has led the process, with international and national technical assistance provided by UNICEF and other development partners to facilitate the review and consultation process.

23. While developing RCH strategy, the focus has been put especially on interventions to tackle maternal and child deaths. The RCH Strategic plan identifies the priorities, must evolve and build on the lessons learned as we go along and envisage incremental introduction of other reproductive and child health services in the medium and longer-term framework as appropriate.

F. Organization of Health Services

24. The country's health service delivery is pluralistic with government, religious missions, local and international NGOs, and the private sector as the main providers. There are public, private for profit, private non-profit and traditional medicine practices. The Government has already passed the following acts in the context of the Civil Service reforms: Hospital Boards Act of 2003; and the Local Government Act of 2004. Both Acts seek to devolve responsibility and accountability of some government functions to the local level for effectiveness and efficiency of service delivery.

The health service organization is based on the primary health care concept which was started in the 1980s. The public health delivery system comprises three levels: (a) peripheral health units (community health centers, community health posts, and Maternal and Child Health posts) for first line primary health care; (b) district hospitals for secondary care; and (c) regional/national hospitals for tertiary care.

25. As part of the public sector reforms that started in 2003, the Ministry of Health and Sanitation is now organized into two main divisions[27] at the central level: medical services and management services. The divisions are headed by Director-Generals who report to the Minister and the Deputy Minister. The divisions have directorates which are headed by directors. Each directorate is further subdivided into programs managed by program managers. The director for Internal Audit reports directly to the Minister and the deputy.

26. The District Health Services form the core component of primary health care. It is comprised of a network of peripheral health units (PHUs), the district hospital and the District Health Management Team (DHMT). The PHUs are the first line health services, and are further sub-classified into three levels. The maternal and child health (MCH) posts (MCHPs) are at village level for populations of less than 5000 and staffed by MCH Aides and supported by community health volunteers and Trained Traditional Birth Attendants (TBAs) to provide antenatal care services, supervised deliveries, postnatal care, family planning, growth monitoring and promotion for under-five children, immunization, health education, management of minor ailments, and referrals of cases to the next higher level.

27. Community Health Posts (CHPs) are at small town level with population between 5,000 and 10,000 and are staffed by State Enrolled Community Health Nurses (SECHNs) and MCH Aides. They provide the same types of services that are provided at the MCHPs but they also include prevention and control of communicable diseases and rehabilitation. They refer more complicated cases to the Community Health Centers (CHCs) which are located at Chiefdoms, usually covering a population ranging form 10,000 to 20,000 and staffed with a community health officer (CHO), SECHN, MCH Aides, epidemiological disease control assistant and environmental health assistants. They provide all the services provided at the CHP level in addition to environmental sanitation and supervise the CHPs and MCHPs within the Chiefdom.

28. The District Hospital is a secondary level facility providing back-stopping for the PHUs. It provides the following services: outpatient services for referred cases from PHUs and the population living within its immediate environs, inpatient services, diagnostic services, management of accidents and emergencies, and technical support to PHUs. The District Health Management Team (DHMT) is responsible for the overall planning, implementation, coordination, monitoring and evaluation of the district health services under the leadership of the District medical officer. Other members include medical officer in-charge of district hospital and schedule officers for various programs of the MOHS.

[27] Annex 2.2.4a: Central Ministry of Health and Sanitation Structure [MOHS 2006]

Religious missions and other NGOs own about 20 percent of the health facilities in Sierra Leone and employ about 30 percent of health sector personnel. They provide inpatient and outpatient curative care and a wide range of family and reproductive health services with a particular focus on MCH/FP. The private sector is weak and is involved mainly in curative care for inpatients and outpatients on a fee-for-service basis. Private health facilities operate under the authority of individual owners and/or boards of directors, mainly in urban areas. The non-poor tend to use private health facilities more often than the poor. Traditional healers and Traditional Birth Attendants (TBAs), are reported to be providing a significant amount of health care. TBAs attend to almost 90% of the deliveries at the community level. The GOSL is exploring ways of cooperating with Traditional healers in the care of patients. A starting point is an inventory of all traditional healers.

G. Human Resources for Health

29. Due to the protracted civil war, Sierra Leone has experienced a high level of attrition in all categories of health professionals engaged in the public sector. The result has been a high ratio of the population to professionals in the various categories of health service providers and further limitations to access to health care services. The number of trained health care providers in general is considerably lower than what is required to provide good health services in the country. Available data from the MOHS in 2004 indicate that there are a total of 120 doctors in general and specialized practice in Sierra Leone, representing a population/doctor ratio of 40,695 per doctor compared to the WHO recommended ratio of 10,000 per doctor. Most of these doctors are based in urban centers and in private practice.

30. Nurses, of which 433 are State Registered Nurses (SRN), constitute the largest cadre of trained health care providers. The population per SRN ratio is estimated at 11,416 per nurse compared to the WHO recommended ratio of 5,000 per nurse. Other nursing support services are provided by 632 Nursing Aides and 333 Maternal and Child Health Aides. There are 115 Registered Pharmacists in the country, with only 15 working in the public sector, supported by 108 Dispensing Technicians. There is an acute shortage of Specialists in Anaesthesiology and Radiology, Laboratory Technicians, Blood Bank Technicians, Administrators, and Medical Equipment Maintenance Specialists. A significant proportion of MOHS training is conducted locally in the seven in-country health training facilities, the National School of Nursing, the National School of Midwifery, a Para-Medical School, a School of Hygiene, the School for Training Pharmacy Technicians, and the College of Medicine and Allied Health Sciences. The universities play a major role in training in research, administration and management. The GOSL has agreed with development partners that the best way forward is to intensify support to human resource development through increased provision for staff training and appropriate technical assistance in the planning, implementation and management of development assistance.

H. Health Care Financing

31. The existing health care financing arrangements are based on the assumption that the majority of Sierra Leoneans can complement government's financing of the health services through the payment for drugs at the point of service. However, in a country where over 70% of

the population lives below the poverty line, there is need to reduce the burden of the cost for health care among households.

Table 2: Fiscal Year, Budgetary Allocation, % of Gvt. Budget allocated to the sector and % of GDP 2004-2007

Fiscal Year	Budgetary Allocation in Billion Leones	% of Gvt. Budget allocated to the health sector	% of GDP
2004	36.6	13.95	1.34
2005	34.4	12.82	1.02
2006	38.4	12.42	0.89
2007	46.3	13.93	0.92

Source: Ministry of Finance: "Recurrent and Development Estimates" (Parliamentary copy), 2003-2005 and MOHS

32. In an attempt to minimize the impact of growing financial difficulties, the GOSL introduced a cost recovery program in 1986 as part of a comprehensive health financing strategy to augment the budget for the procurement of medicines and medical supplies while effectively protecting those who cannot afford to pay. This policy decision stipulates that MOHS maintains an indirect subsidy on all drugs dispensed by health units, as well as a single fixed fee for drugs dispensed by the rural health care facilities. All preventive activities (such as vaccinations) will continue to be free for the whole population. This is in line with the Bank Group *Operational Guidelines On User Fees In Health And Education*, which supports 'free essential health services' that include immunization, maternal and child health care and HIV/AIDS, sexually transmitted infections, malaria and tuberculosis. By the start of the escalation of the civil war in 1999, the cost recovery program was functional in all thirteen districts. The program was disrupted by the protracted civil war. The current policy allows health facilities to retain 10% of the revenues collected through cost sharing for development and maintenance, minor operational costs and an additional 10% for improved district administration.

33. To address the issue of affordability and coverage of quality health care, which is critical to improving the well being of the poor, Government has declared that medicines will henceforth be free for the 'vulnerable groups', which includes pregnant mothers, children under 5, prisoners, school children, amputees, the poor, and the elderly. These groups account for over 70% of those who use the health services. In addition, many NGOs are providing medicines free of charge. The GOSL has also adopted the Bamako Initiative, which aims to define and implement PHC self-financing mechanisms and encourage social mobilization for community participation, The initiative includes efficiency measures such as fee collection, management system and public/private sector partnership. The training of community representatives and health staff, formation/reactivation of Village Development Committees, and the provision of seed stocks of essential medicines are being revitalized.

I. Decentralization of Health Services

34. Local Councils were elected in May of 2004 in each of the 13 districts of Sierra Leone and in the 6 major towns. Decentralization consists of transferring money and authority for various public services from the central ministries in Freetown to the Local Councils who work with the district-level staff. One of the first ministries to be decentralized was the Ministry of Health and Sanitation. Starting in the third quarter of 2005, tied grants amounting to about a quarter of the national health budget were transferred to the Local Councils. [28] These grants are supposed to cover activities such as vaccination campaigns, epidemic control, infrastructure improvements and expansion, and the operational expenses of the District Health Management Team (DHMT). In practice, many Local Councils turn these grants over to the DHMT who plan the activities and manage the funds with varying degrees of supervision from the Local Council. Procurement and supply of drugs and payment of staff are still managed through the Ministry in Freetown.

35. A total of 8.5 million Leones, representing almost a quarter of the national health budget, was budgeted for these grants in 2005. The first grants, however, were not made until late in the third quarter of 2005 and thus just under half of the budgeted money was actually disbursed to the councils in 2005. In total, 3.8 billion Leones (approximately 1.3 million US dollars) was disbursed to the Local Councils in 2005.[29]

36. In 2006, Local Councils received grants each quarter to cover "district peripheral health care services," "registration of births and deaths," "environmental health care services," "public health information, education and communication," and "facilities management." The bulk of this money (85%) is for "district peripheral health care services." In total, 9.1 billion Leones (approximately 3.0 million US dollars), representing just under one quarter of the national health budget, was budgeted for these services in 2006 and over 99% of it was disbursed. It appears that the situation has worsened in 2007 because the GOSL has collected much less revenue than expected.

37. During the Devolution Orientation workshop organized for MOHS staff, District Medical Officers, LC Chief Administrators, and Local Council Health Committee Chairpersons, the roles and responsibilities of various parties were explained. DMOs effectively are now "Directors of Health" in the local councils and are in charge of developing and implementing local council health service improvement plans and programs. Each DMO is a member of the management team in the administrative and technical wing of the councils. The performance of the health sector programs will be closely monitored by the Local Council Health Committees.

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[28] This team is lead by the District Medical Officer (DMO) and is responsible for the management of primary health care at the district level, including running the district hospital as well as overseeing and supplying the clinics in the district.

[29] Therefore the distribution is based on population and number of health facilities, primary or secondary as the case may be, and each factor is weighted The weighting factor is: FCH = (w1 PC/P + w2 HFC/HF)*FH Where FCH is the funding entitlement of council out of a pool FH for Other Primary/Secondary Health Care Services (excluding amount for drugs), as the case may be.
PC is council's population, P is the national population, HFC is the number of health facilities in council and PF is the national total of health facilities as applicable. w1 and w2 are weights attached to the two factors.

38. The district health teams were trained in the Rapid Results Approach. Since the disbursement of health grants, all councils are adopting the implementation disciplines underlying the Rapid Results Approach in accelerating their routine responsibilities, such as immunization, health education, birth and death registration, and pre-natal care.

39. The IRCBP research recently completed a study assessing the experience of decentralization after one year. The report summarizes data collected on primary health care facilities in October 2006. It describes the state of primary health care after the first year of substantial decentralization in the health sector, and compares this to similar data collected in October 2005 to describe the changes that have taken place in primary health care over a period in which the Local Councils had increasing authority and resources to manage various aspects of primary health care.

Main Findings:

- Clinic quality has improved significantly on 6 of the 8 measures we test (the other two – water and utilization – show no significant change).
- Clinic infrastructure is quite good although a significant number of clinics lack a good water source and a refrigerator.
- Absenteeism of clinic staff is high in absolute terms (42 percent), although low relative to other countries of similar income level.
- Over a third of staff who should be on the government payroll report not being paid, and those who are paid report significant delays in receiving their salaries.
- Drug supplies have improved, but almost two thirds of clinics lack at least one key drug and over 60 percent of clinics buy drugs from pharmacies.
- Community committees play an important role in setting clinic policies and supporting the clinics.
- Local Councilors have little direct involvement with clinics and are not seen as making decisions on primary health care delivery, but the influence of District Health Management Teams has increased.
- Clinic staff perceive that there has been a significant shift in authority from the Ministry of Health to District Health Management Teams on a number of issues, and that clinic staff have increasing authority on other issues.

ANNEX 2: MAJOR RELATED PROJECTS FINANCED BY THE BANK AND OTHER AGENCIES

SIERRA LEONE: Reproductive and Child Health Project

1. Most of the donor funding is targeted at either specific programs or selected districts. The World Bank is supporting the strengthening of health systems through rehabilitation works and provision of equipment and logistics in four districts (Koinadugu, Bombali, Kono and Moyamba). The European Union is also supporting Kambia, Pujehun and Kailahun districts whereas the African Development Bank and the Islamic Development Bank are funding the rehabilitation of three major hospitals in the capital, Princess Christian Maternity Hospital, Children Hospital & Connaught Hospital), and expansion of the Kissy Mental Hospital respectively. The UN agencies and bilateral organizations such as USAID support capacity building and the provision of services. The funding is either channeled through the MOHS to specific programs through NGOs or directly to specific districts through the provision of equipment and logistics, rehabilitations and training.

Table 1: List of major donors and UN agencies and areas of support

DONOR/ UN AGENCY	DESCRIPTION OF SUPPORT
World Bank (IDA)	The Health Sector Reconstruction and Development Project (HSRDP) supports 16 Cost Centers. These include four districts (Bombali, Koinadugu, Kono, and Moyamba), four district hospitals (Kabala, Makeni, Koidu, and Moyamba), four National Technical Programs (Malaria Control, TB/ Leprosy Control, Onchocerciasis, and Environmental Sanitation), as well as the vital areas of Planning and Information, Financial Resources Management, Internal Audit, Human Resources Management, Architectural Services, Procurement, and Donor/ NGO Coordination. This project is funding the rehabilitation of the hospitals in the above-mentioned districts, as well as three "satellite" Community Health Centers in each. Supplemental financing of US$8 million has been approved and the closing date extended to 2009. The Institutional Reform and Capacity Building Project (IRCBP). The US$25.12 million IRCB Project was approved in May 2004 and became effective on July 6, 2004. It has four components: Decentralization and Capacity Building, Public Financial Management Reform, Development Learning Center, and Project Coordination. The project was rated satisfactory at the mid-term review.
African Development Bank	Rehabilitation of the National Referral/ Tertiary Hospitals in Freetown, namely Connaught, Princess Christian Maternity, and Children's Hospitals. In addition structural rehabilitation of 5 Community Health Centers in the Western Area, training of staff, provision of equipment, drugs, supplies, and vehicles. This Health Sector Rehabilitation Project is delayed; it was expected to be fully completed in March 2006. Meanwhile, another project to support District Primary Health Care Services (in Bonthe, Kenema, Bo, Port Loko, and Tonkolili Districts) has been approved but has not been launched as planned for March 2006; it is also delayed.
European Union	The Health Sector Support Project focuses on strengthening Primary Health Care Services in three districts, namely Kambia, Kailahun, and Pujehun, and providing Technical Assistance to key programs (Human Resources Management, Financial Management, and Administrative Support). Support from the EU is also provided through health NGOs and another project that focuses on the reconstruction of damaged and dilapidated facilities, including health facilities.
Department for International Development (DfID)	Fifty Million Pounds approved for a Sexual and Reproductive Health program over a period of ten years, beginning in January 2008.

DONOR/ UN AGENCY	DESCRIPTION OF SUPPORT
WHO	Country – wide coverage for technical programs like Malaria Control, TB/ Leprosy Control, EPI, and Human Resources. Support primarily through provision of Technical Assistance.
United Nations Population Fund	Focus of assistance is on Reproductive Health/ Family Planning through the provision of condoms and the support for the Emergency Obstetric Care (EmOC) program that aims to strengthen the capacity of district hospitals (Bo, Kenema, Magburaka, Makeni, Moyamba, Port Loko, and Princess Christian Maternity Hospital) to manage obstetric referrals and complications.
UNICEF	Country – wide coverage for technical programs like EPI. Primary Health Care Support focused on four districts, namely Koinadugu, Bombali, Kailahun, and Moyamba.
USAID	Support through International Health NGOs like Africare, International Medical Corps, and Helen Keller International, focusing on the most needy districts like Kailahun, Kono, and Kenema.
Health Metrics Network (HMN)	The HMN has supported various HIS stakeholders (MOHS, SSL, and partners) to develop an HIS Strategic Plan. HMN support will extend beyond catalytic funding to more intensive technical support and resources. Initial priorities include the development of a computer based information system to permit improved data management, analysis, dissemination, and use.
UN Foundation	Support is being provided in two areas: monitoring, evaluation, and supervision of reproductive and child health services and provision of assistance to behaviour change.

2. Some NGOs and religious organizations such as Marie Stopes Foundation, Christian Association of Sierra Leone, Medicine Sans Frontiers (France, Belgium, and Germany) and International Medical Corps are providing services through their own health facilities. Others are providing their support at the district either through the district health services or directly to communities by way of capacity building, logistics support or social mobilization and health education. Some international initiatives such as the Global Fund for HIV/AIDS, tuberculosis and malaria, and the Global Alliance for Vaccines and Immunization are providing funding for these programs.

ANNEX 3: RESULTS FRAMEWORK AND MONITORING

SIERRA LEONE: Reproductive and Child Health Project

1. Given the APL approach of the project, a LogFrame has been prepared in lieu of a results matrix in order to better show the relationships between the three different phases of the Program. The indicators selected for Phase 2 are indicative only covering a variety of elements of the program that will be required to achieve the program's development objective such as utilization, access and availability of essential health program.

Phase 1 Project LogFrame

Narative Summary	Proposed Targets and Key Indicators	Monitoring and Evaluation	Critical Assumptions
Program Development Objective (2008-2016) Improved sexual, reproductive, and child health indicators	• U5MR reduced from 267 to 100 by 2016 • Maternal mortality ratio reduced from 1300 to 500 by 2016 • Total Fertility Rate reduced from 5.72 to X	Every 2.5 years, DHS and MICS, Census (for MMR)	• Macroeconomic and political stability • Continuity and consistency in the development of health policy
Phase 2 Development Objective (2008-2011) Contribute to the 10 year goal of reducing maternal and child mortality	• Under Five Mortality rate reduced between 10-20% from 267/1000 live births by 2011 (expected progress target toward the ten year program goal) *Selected Service Indicators: Indicative only* • % of children under five years who slept the previous night under an ITN increased (utilization/behavior) • Contraceptive prevalence rate (service provision) • % of deliveries attended by a skilled birth attendant (service coverage) • % population living within 5 km of a facility offering comprehensive essential obstetric coverage (service availability)	DHS, MICS, and monthly Integrated Child Survival (ICS) forms	• Adequate funding is provided on time by development partners and GOSL • Implementation capacity of GOSL is sufficient to manage direct implementation and lead and oversee NGO implementation of activities

Phase 1 Development Objective (Results of the Phase 1 (October 2007-March 2008) Assist the Recipient in addressing immediate constraints to reducing longer-term maternal and under-five mortality and strengthen readiness for phase 2 implementation	The following has been achieved in at least 10 of the 13 Districts:[30] • the percentage of pregnant women who made their first ANC visit between January 1, 2008 and June 30, 2008 increased by at least 10% • The percentage of infants who received their first dose of penta vaccine between January 1, 2008 and June 30, 2008 increased by at least 10 percent • 90% of PHUs submitted their Integrated Child Survival Forms to the DHMT within 15 days of each month for the three month period beginning on April 1, 2008	IRCBP procurement reports, ICS, PHU quarterly supervision forms	Political changes result in loss of ownership and commitment Cross sectoral implementation is not sufficiently coordinated NGO activity is not coordinated and thus resources are not allocated optimally between districts and to major CSMMRP Preparation of the national strategy is delayed Political-economy issues in the use of skills and in getting workers to local districts/communities are underestimated and thus improperly addressed.
Project Components and Sub-components: 1. Scaling up of Local Council Health Plans 1.1 Family and Community Based Care 1.2 Population Oriented Services 1.3 Clinical Care 1.4 Capacity Building and Monitoring and Evaluation	The following has been achieved in at least 10 of the 13 Districts: • 90% of PHUs in the District are visited by the DHMT between April 1, 2008 and June 30, 2008. • 80% of the community volunteers targeted for training in the Phase 1 District Health Plans is trained. • 80% of PHU staff targeted for training in the Phase 1 District Health Plans is trained.	Progress reports from IRCBP with input from MOHS	
2. Project Management, Monitoring, and Evaluation		Progress reports from IRCBP with input from MOHS	
Inputs			
1. Scaling up of Local Council Health Plans	US$ 5.6 million		
2. Project Mng, M&E	US$ 0.4 million		

[30] Baselines are specific to each district and thus are not included in this matrix. District level targets are on the next page. Baseline data will be available prior to effectiveness.

Arrangements for results monitoring for Phase 1

2. Responsibility of monitoring will be jointly with the MOHS and IRCBP. The MOHS has recently introduced three key tools to strengthen M&E in the district and national level. All of these tools can be found in the project file:

- Integrated District-Level Supervisory Visit to Health Facilities:

  All DHMTs are expected to visit all their PHUs every quarter. PHU supervision is done using a new PHU checklist that has been entered into PDAs. At the end of each round of supervision, the data in the PDAs are downloaded and analyzed. These forms allow the MOHS to collect information on whether supplies procured under the project are being used and the quality of training. The data for each district are sent to the national level at the end of each quarter and can be cross checked with similar information collected by the DPI (see below).

- The Health Facility Quarterly Supervision Report:

  Independent of the DHMT supervision of PHUs, the DPI also conducts quarterly supervision reports in about 10-15% of the PHUs in each district. During these visits, the DPI uses a structured supervision checklist. The checklist included key observable features that are considered to be critical to health care delivery. The rationale is that if all/most features of the checklist are in place, the supervisor and staff member can feel assured that the facility is performing up to expected standards. Alternatively, missing elements require attention and serve to highlight areas needing improvement. The checklist covered the following areas: Infrastructure, personnel, availability of essential medical supplies, antenatal attendance, immunization coverage, maternal care, water and sanitation, family planning and record keeping and reporting. The DPI prepares a quarterly supervision report which can be used to compare performance by district. Amongst other things, the forms have proven to be helpful in raising the morale of the health workers who are encouraged by the fact that their efforts are being recorded and that the difficulties they are facing are being addressed.

- Integrated Child Survival Forms:

  Health facilities report to their respective district at the end of each month, using these tools. The District Monitoring and Evaluation Officers enter the data received from individual health facilities into a district database and produce reports which are forwarded to the national level for compilation, analysis and dissemination. The child health component of this tool collects data on immunization, bednet usage, nutritional status, prevalence and management of the three main killer diseases for children in Sierra Leone (malaria, acute respiratory infections and diarrhea) and under-five deaths. The maternal health aspect of the tool collects information on antenatal attendance, bednet usage, access to intermittent preventive treatment with sulphadoxine/pyremethamine, immunization against neonatal tetanus, institutional delivery, skilled delivery and

maternal death. There is a tool for collecting information on availability of basic health commodities, drugs and supplies.

3. In order to facilitate efficient use of information, review meetings will be conducted at district and national levels during Phase 1. District level review meetings will be conducted on monthly basis and these will be attended by DHMT members, in-charge of health facilities in the districts, NGOs operating in the districts, local council representatives, and community leaders. National level review meetings will be conducted annually and will be attended by senior MOHS officials, program managers, District Medical Officers, Local Council representatives, Parliamentarians, NGOs, donors, UN agencies and civil society representatives.

4. The LGFD will prepare quarterly project interim financial reports (IFR) in the areas of finance, procurement, including complaints from bidders, and project progress. The financial management system put in place should be capable of producing these reports.

5. The following reporting arrangements have been agreed upon for Phase 1. The Director of the LGFD will report to the MOHS on the fiduciary aspects of the project and the Director of Primary Health Care of the MOHS will report on the technical aspect of the project. The IRCBP Coordination Unit will consolidate the information in an agreed format and provide a quarterly report to the MOHS and the Development Partners accordingly.

Arrangements for Results Monitoring for Phase 2

6 Phase 2 will use the forms that are tested during Phase 1 to monitor routinely report health statistics. Supported by the HMN project, Phase 2 will continue to build the capacity of Monitoring and Evaluation Officers (two in each district plus one with each hospital or public health program) to support data management and thus assure more timely and complete reporting, analysis and use of health statistics. This will involve both in-service training (initially) and, in the intermediate-term, pre-service instruction of a more highly qualified cadre of M&E professionals.

7 Phase 2 will also draw upon population based and facility based surveys. Some of these are being conducted now in order to have accurate population baseline data for Phase 2. Ongoing and planned surveys include:

- Core Welfare Indicator Questionnaire – Data have been collected and are being analyzed. The survey will provide up to date population-based estimates of key population-based maternal and child health indicators (e.g. coverage with immunization, antenatal care, supervised delivery, ITNs, prevalence of exclusive breastfeeding).
- Nationally representative household surveys (DHS or MICS) will be conducted each 2.5 years to track child and maternal mortality, key household and community practices, and service coverage, and to identify geographic/socio-economic disparities in these indicators.
- Maternal mortality will be measured precisely with the 2014 national population census. Use of the census to map the distribution of health professionals (private as well as public sector) is also under consideration. Investment in and full use of the already solid

cartographic capacity and Geographic Information System database of Statistics Sierra Leone will permit accurate estimation of catchment areas and geographic access to health services.

- Health facility censuses will be conducted each 1 to 2 years -- to track infrastructure, human resources and services
- National health accounts will be completed for the first time in 2007 and updated annually thereafter.

8. The performance monitoring plan includes proposed indicators for Phase 2. There are three sets of indicators. National and district level *core* health indicators for M& E of the health sector at the national and district levels; a *more extensive* list of indicators for M&E of specific reproductive and child health interventions and a set of indicators that can be used as the basis for the output-based disbursements to districts.

9. An integrated data warehouse will bring data together at district level from multiple routine sources (specific vertical programs, surveillance, facility services, logistics, human resources, MOF) to provide regular summaries for action at the district level (DHMTs and local councils), feedback to health facilities and timely, complete electronic transmission to multiple users at national level.

Performance Indicators		Bo	Bombali	Bonthe District	Kailahun	Kambia	Kenema	Koinadugu	Kono	Moyamba	P Loko	Pujehun	Tonkalili	W Region	TOTAL
AT LEAST 10 OF THE 13 DISTRICTS ACHIEVE THE FOLLOWING TARGETS															
% of pregnant women who make their first Anti Natal Care visit between January 1, 2008 and June 30, 2008 increased by at least 10 percentage points	B	55%	61%	48%	53%	55%	57%	49%	58%	55%	53%	52%	51%	58%	56%
	T	65%	71%	58%	63%	65%	67%	59%	68%	65%	63%	62%	61%	68%	66%
% of infants receiving first dose of penta vaccine between January 1, 2008 and June 30, 2008 increases by at least 10 percentage points	B	48.1%	61.7%	56.7%	38.0%	59.5%	50.3%	68.5%	78.7%	62.5%	52.3%	38.0%	58.8%	37.8%	51.1%
	T	58.1%	71.7%	66.7%	48.0%	69.5%	60.5%	78.5%	88.7%	72.5%	62.3%	48.0%	68.8%	47.8%	61.1%
80% of training of PHU staff in the 2007 DHP is completed	B	n/a – new activity													
	T	48	225	108	140	336	168	163	149	512	124	650	662	216	3504
80% of training of Community Volunteers in the 2007 DHP is completed	B	n/a – new activity													
	T	965	2326	342	486	810	1996	1012	324	621	90	1416	1026	216	11631
90 % of PHUs are visited by the DHMT between April 1, 2008 and June 30, 2008	B	n/a – new activity													
	T	25	226	99	93	90	190	91	127	153	172	135	124	144	1674
90% of Integrated Child Survival forms are submitted by the PHUs to the DHMT within 15 days of each month for the three months period beginning on April 1, 2008	B*														
	T	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

*Health facilities did not send their monthly reports in-time because of election activities.

ANNEX 4: DETAILED PROJECT DESCRIPTION

SIERRA LEONE: Reproductive and Child Health Project

Component 1: Scaling-up of Local Council Health Plans ($5.6 million)

Component 1 is dedicated to assisting the Recipient in addressing immediate constraints to reducing longer-term maternal and under-five mortality. Support will be provided through sub-grant agreements between LGFD and each Local Council (Annex 15) to finance the activities specified in the Phase 1 health plans approved by the LCs, MOHS, and the Bank (available in the Project files).

The scaling up plans are organized by service delivery mode: family community based care, population oriented services, and clinical care.[31] A fourth sub-component is intended to strengthen capacity for management and monitoring and evaluation.

Delivery Mode 1: Family and Community Based Care: Poor access to information and to networks distributing health-related commodities is a major impediment to the use of community- and family-oriented support to self-care. The right home self care -practices can make a difference to health outcomes. Home-based practices, from good nutrition, safe handling of water and waste disposal, and prevention of substance abuse to home care for illnesses are a major avenue to good health outcomes in both rich and poor countries.[32] Obstacles to broader adoption of these practices are often related to insufficient information and weak decision-making capacity of women, a result of low levels of literacy. Rural populations often have no access to insecticide treated bed nets, soap, water containers or essential drugs for home care. If they do, price remains a barrier. Interventions like timely initiation of breastfeeding (within 1 hour of birth), exclusive breastfeeding of infants 0 - 6 months has increased significantly in these countries. In addition, the efficacy of appropriate complementary feeding has also the potential to reduce U5MR by 6% at high coverage.

Implementation of the following high impact interventions will be supported:

- prevention of malaria using ITNs for pregnant women and infants – preventive measures, especially the use of mosquito nets treated with insecticide (ITN) can dramatically reduce the malaria morbidity and mortality rates among children

- promotion of hand washing by mothers – poor personal hygiene is associated with a range of diseases including diarrheal diseases and polio.

[31] This is consistent with the approach endorsed by the Africa Union and described in "A Strategic Framework for Reaching the Millennium Development Goal on Child Survival in Africa: Through Health System Strengthening and implementation at Scale of Integrated Packages of High-Impact and Low-Cost Health and Nutrition Interventions, September 2006.

[32] Hill, and Kirkwood, September 2001

- chlorination of wells to ensure access to safe water – unsafe drinking water can be a significant carrier of diseases such as trachoma, cholera, typhoid and schistosomiasis.

- improved neonatal care by ensuring clean delivery and cord care – ensuring a clean delivery reduces the chance of the neonatal infection

- promotion of early, exclusive, and prolonged breastfeeding – breastfeeding for the first few years of life protects children from infection and provides an ideal source of nutrients. It is economic and safe. Many mothers stop breastfeeding too soon and there are often pressures to switch to infant formula which can contribute to growth faltering and micronutrient malnutrition and is unsafe if clean water is not readily available.

- promotion of use of oral rehydration solution (ORS) for diarrhea – using ORS can greatly reduce the morbidity and mortality from diarrhea

- community based treatment of children with malaria with artemesinin based combination therapy (ACTs) – in areas where malaria is common, international recommendations suggest treating any fever in children as if it were malaria and immediately giving the child a full course of recommended anti-malaria tablets. ACT are preferable because their combination of artemesinin with at least one other drug reduces the possibility of developing resistance as has been the case with chloroquine.

Delivery Mode 2: Population Oriented Services. Most countries have had some success in increasing the physical access of poor communities to population-oriented services through outreach or scheduled facility based sessions. Access to standardized and schedulable services can be improved through regular outreach sessions in villages that do not have a health center of resident professional health worker: routine immunization, vitamin A distribution, antenatal care, family planning, growth monitoring, malaria prophylaxis, deworming and health/nutrition education These supplementary periodic efforts can be effective in reaching hard to reach –often poor and marginalized- groups, as demonstrated by campaigns and mobile activities in the Universal Childhood Immunization successes of the 1990s and the more recent reduction of Vitamin A deficiency. These "campaign" modes of delivery are very sensitive to top-down control and financing, with peaks of high coverage linked to special efforts. Governments can control and monitor such services easily. But sustainability is often questioned, and opportunity costs may be high.

This component will support the following interventions:

- preventive pregnancy care which includes antenatal care, situational IPT for malaria, and tetanus immunization – these interventions reduce the that the chance of the neonate developing a severe infection which can lead to death.

- preventive infant and child care which includes provision of measles immunization, Diphtheria, Pertussis and Tetanus, and Vitamin A – according to UNICEF and WHO guidelines, a child should receive a Bacillus Calmetle Guérin vaccination to protect

against tuberculosis, three doses of Diphtheria, Pertussis and Tetanus to protect against diphtheria, pertussis and tetanus, three dose of polio vaccine and a measles vaccination by the age of 12 months.

Delivery Mode 3: Clinical Care. Continuously available clinical services are also needed for many interventions that are critical for achieving the Millennium Development Goals, such as skilled attendance at childbirth and obstetrical emergencies, management of neonatal distress and acute and serious childhood illnesses. Availability and physical access to qualified health workers, affordability of services for the poor, and protection from catastrophic illnesses remain the most pressing issues for delivering these services. These services are delivered at PHUs with the presence of skilled health professionals. The project will finance goods, medical supplies, training, treatment protocols, IEC, and operating costs in order to:

- Ensure skilled care deliveries by training PHU and hospital staffensuring that PHUs are able to provide basic emergency obstetric and immediate neonatal care (B-EONC) – the provision of delivery assistance by skilled attendants can greatly improve outcomes for mothers and infants through the use of technically appropriate procedures as well as accurate and speedy diagnosis and treatment of complications.

- Antiobiotic treatment for pneumonia,– at the global level, pneumonia is the leading cause of death in children and the use of antibiotics in under-5s with suspected pneumonia is an important intervention to reduce severe morbidity and mortality in children.,

Capacity Building and Monitoring and Evaluation. The objective of this sub-component is to support capacity building for the DHMT and ensure that the new Monitoring and Evaluation system is functioning properly. It will finance training, office equipment and supplies, technical assistance, and incremental operating costs.

Component 2: Project Management, Monitoring, and Evaluation ($0.4 million)

This component supports the building of capacity of the IRCBP Coordinating Unit, the LGFD, and the MOHS, for the coordination, implementation, monitoring and evaluation of the Project through the provision of technical advisory services, equipment, vehicles, operating costs and training.

ANNEX 5: PROJECT COSTS

SIERRA LEONE: Child Survival and Maternal Mortality Reduction Project ('000 US$)

	Local	Foreign	Total
A. Phase 1 Local Councils' Health Plans	3,063	2,501	5,564
B. Project Management and M&E	0.196	0.240	0.436
Total Project Costs	**3.259**	**2.741**	**6.000**

Category of Expenditures	**Total Grant Financing (US$)**	**% Grant financing [1/] (including taxes)**
(1) Subgrants consisting of Goods/Services/Training and Operating Costs for Component A	5,564,000	100%
(2) Goods/Services/Training and Operating Costs etc. for Component B	436,000	100%
Total	**6,000,000**	

[1/] According to agreed Country Financing Parameters.

Disbursement Table

S. No.	Category Description	Allocation (US$)	% Eligibility
1	Goods	4,500,530.00	100
2	Consultancy and Training	944,095.00	100
3	Operating Costs	555,375.00	100
	Total	**6,000,000.00**	

Estimated Cost by Component and District (US$ '000)

Components/Sub-components	Bo	Bombali	Bonthe District	Bonthe City	Kailahun	Kambia	Kenema	Koinadugu	Kono	Moyamba	P Loko	Pujehun	Tonkalili	W Region Urban	W Region Rural	TOTAL
A. Scaling-Up Local Councils Health Plans																
1.0 Family and Community Based Care	67	130	19	1	11	82	94	133	101	101	13	178	48	102	37	1116
1.1 Environmental Care	36	33	3	0	0	35	61	45	82	17	0	104	12	7	0	435
1.2 Family Neonatal Care	17	22	4	0	5	12	13	83	0	10	7	2	5	55	11	246
1.3 Infant/Child Feeding	13	62	1	1	6	31	20	0	11	52	6	39	19	13	26	300
1.4 Community Based Illness Management	1	13	12	0	0	3	0	5	8	22	0	33	12	27	0	136
2.0 Population Oriented/Outreach Services	70	69	55	14	314	120	277	167	148	163	308	322	151	202	231	2611
2.1 Preventive Pregnancy Care	63	33	36	13	298	82	247	3	140	65	216	200	61	100	194	1751
2.2 Preventive Infant and Child Care	7	36	19	1	16	38	30	164	8	98	92	122	90	102	37	860
3.0 Improve the Institutional Service Delivery	22	62	54	31	11	10	0	7	6	192	90	8	135	146	50	824
3.1 PHU level care for Maternal and Neonatal Care	0	40	18	10	11	3	0	2	1	37	30	0	108	70	20	351
3.2 PHU level care for Child and Adult care	22	10	18	10	0	3	0	5	4	51	30	8	14	63	20	259
3.3 Referral services for Illness Mgt	0	12	18	10	0	3	0	0	1	104	30	0	13	13	10	215
4.0 Strengthen the administrative, and M&E capacity of the DHMT	64	93	86	0	40	71	0	98	80	60	41	139	115	120	5	1013
4.1 Capacity Building for the DHMT	60	84	43	0	37	46	0	48	40	30	21	31	90	100	0	631
4.2 Disease Surveillance and M&E	4	9	43	0	3	25	0	50	40	30	20	108	25	20	5	382
B. Project Management and M&E																
4.3 Project Management																436
	223	354	214	45	376	282	371	405	335	516	452	647	449	570	323	6000

NOTE:
If activity falls in different sub-objectives within a main objective, has been divided equally between all sub-objectives
If activity falls in different objectives (main) was allocated to the lower level
Based on US 1$ = SL 3,000

ANNEX 6: IMPLEMENTATION ARRANGEMENTS

SIERRA LEONE: Reproductive and Child Health Project

1. A National Health Policy Advisory Committee has been recently established and is responsible for oversight and strategic coordination of all actions foreseen under the sector. It provides policy decisions and directions for improvements of the health status of the population. It also coordinates all efforts in the health sector and in particular the reduction of child and maternal mortality as immediate priority. A National Steering Committee for Sexual, Reproductive and Child Health (NSCSRCH) chaired by the Director General of Medical Services also recently established, is responsible for effective implementation of policies and programmes and for greater coordination and collaboration among stakeholders. Technical directorates and units at the central, regional, and district levels are given full and direct responsibility for implementing their activities according to agreed upon Annual Work Plan and priorities as set by the MOHS in support of the National Health Development Plan (NHDP).

2. IRCBP: The Local Government Finance Department (LGFD), established within the MOF, located within IRCBP Secretariat, has the task of managing the financial arrangements by which councils are to operate and to undertake the management of fiscal decentralisation through devolution of functions including the management of IRCBP-financed Local Government Development Grants (LGDG).

3. The LGFD is to make annual recommendations on the distribution of grants to the councils; and to monitor the financial and physical performance of the councils in the development of services and their capacity to deliver.

Phase 1 Institutional and Implementation Arrangements

4. Phase 1 builds on on-going health-related activities that are being implemented by the Local Councils (LCs) and district health management teams (DHMTs).

5. Each LC has an annual health development plan that is prepared and reviewed by the DHMT and approved by both the local council and the MOHS. In approving the Phase 1 health plans, the following criteria were used in determining what could be considered eligible for financing under Phase 1:

- Has already been included in the original 2007 annual district plan
- Be proven high impact and cost effective in contributing to reducing child mortality
- Expresses a clear link from activity to output to outcome

6. This supports the on-going decentralization process in Sierra Leone, which the World Bank is supporting through an ongoing project (IRCBP). Through this process, local councils are already managing both Government and World Bank financing, and the ACGF Phase I grant

would be an additional source of funding for the country's health program at the local council level. The flow of funds and financial management of the new grant will follow the procedures used for LGDG funds under the IRCBP (Annex 7).

7. Technical Implementation: The MOHS will have technical responsibilities for the Project in the same manner as for the IDA-financed ongoing Health Sector Reconstruction and Development Project. As such, the Director General of Medical Services will be responsible for project technical implementation. The Director of Planning and Information will ensure coordination between the Local Government Finance Department (LGFD), established within the MOF, the MOHS and development partners. All other top management teams of the ministry will continue to coordinate the scaled-up activities as they do under the HSRDP. A variety of actors at different organizational levels, including the District Health Management Teams (DHMT) and technical program managers at the national level, will be responsible for implementation of activities according to their comparative advantage.

8. The MOHS and its top management team, the various implementing entities at the different organizational levels, including the DHMT and technical managers, which have performed satisfactorily under the HRSDP, will carry out and oversee execution of the new activities.

9. Fiduciary Management and Implementation. The scaled-up activities planned under the 2007 Local Council District Health Plans implemented by the DHMTs will be financed using existing flow of funds mechanisms that are used by the ongoing IRCBP as explained in Annex 7.

10. While the MOHS has ensured technical quality of the Local Councils' District Health Plans and their coherence with the MOHS policy and strategy, the Local Government Finance Department (LGFD) of the Ministry of Finance (MOF) and located within the IRCBP will monitor the financial and physical performance of the LCs in the development of services and their capacity to deliver. The IRCBP Coordination Unit will ensure the day-to-day fiduciary responsibilities for the Project and will liaise with the MOHS for technical inputs. As such, the Unit will manage the designated account opened for the purpose of the Grant. Upon signature by the MOHS (represented by the Chief Medical Officer), the Ministry of Finance (represented by Financial Secretary), and the respective LCs (represented by the Chairman of the LC and its Chief Administrator) of a Sub-grant Agreement (see Annex 15) describing the terms and conditions of the said agreement, the funds will be disbursed in the Local Councils impress account opened for the purpose of the Project. The MOHS, the LGFD, and the IRCBP Coordination Unit will play an oversight role on the technical and fiduciary responsibilities, respectively, by monitoring the Districts/Local Councils to ensure that they are performing and carrying out their responsibilities according to the Sub-grant Agreement.

11. Based on the existing arrangements under the IRCBP, LCs will provide information on the utilization of the Grant as part of the already required quarterly cash flow statement being submitted to LGFD for subsequent quarterly releases. Unlike the current arrangement under the IRCBP, which requires an advance to the Local Councils from a counterpart fund, the first release will be made upon signature of the Sub-grant Agreement from the Designated Account (DA) established for that purpose. Subsequent releases will be made as long as the required financial reports have been submitted on time and if random inspections and audits reveal no

malfeasance. Any local council found in breach of any agreed financial regulations will have its funding stopped, until all recommended actions are implemented.

12. Reporting. The Director of the LGFD will report to the MOHS on the fiduciary aspects of the project and the Director of Primary Health Care of the MOHS will report on the technical aspect of the project. The IRCBP Coordination Unit will consolidate the information in an agreed format and provide a quarterly report to the MOHS and the Development Partners accordingly. More details are provided in Annex 3.

ANNEX 7: FINANCIAL MANAGEMENT AND DISBURSEMENT ARRANGEMENTS

SIERRA LEONE: Reproductive and Child Health Project

Introduction

1. Financial Management Assessment of the Local Government Finance Department was carried out in accordance with the Financial Management Practices Manual issued by the Financial Management Board on 3 November 2005. The objective of the assessment was to determine whether the implementing entity has acceptable financial management arrangements, which will ensure: (1) that the funds are used only for the intended purposes in an efficient and economical way; (2) the preparation of accurate, reliable and timely periodic financial reports; and (3) the safeguarding of the entities' assets.

2. The Assessment was for the implementation of the Reproductive and Child Health Program – Phase 1. Phase 1 is intended to up-scale current activities of the District Health Management Teams in the various districts of Sierra Leone by providing goods and medicaments and equipments for the teams to assist in addressing immediate constraints to longer-term maternal and under-five mortality. Phase 1 will be implemented over six-month duration unless the duration is extended by mutual agreement between the ACGF and the Government of Sierra Leone.

Country Issues

3. A Country Financial Accountability Assessment for Sierra Leone was carried out in 2001, weaknesses identified, and proposals made for the improvement of Public Financial Accountability there-from. The Bank has recently undertaken a Public Financial Management Assessment (PFMA), whose result is awaiting publication. The government has reacted positively since, and made particular use of the IDA financed Institutional Reform and Capacity Building Project, has embarked on a series of reforms in the general area of public expenditure management. These include:

- Enactment of the Government Budgeting and Accountability Act 2005 and the Public Procurement Act 2004.
- Implementation of the free balance financial management information system in the Accountant General's Department in June 2005. This is providing effective internal controls on transactions, and enabling quarterly reporting within 3 months of the period end. Rollout of the system has been made to the police department, and is underway in the Ministry of Finance.
- Establishment of manual book-keeping procedures, with a high level of compliance in most of the Local Councils, and including the posting of monthly statements on Council notice boards.
- Closing of the gap between the budget and actual expenditures, and some improvement in the predictability of releases, including to local councils by the end of 2006.

- Improvement in the budget calendar allowing the 2007 submission to Parliament two months before the start of the year, and development of strategic plans in the major social service and economic sector ministries.
- Establishment of the National Public Procurement Agency and Procurement Review Panel. Development of procurement plans for all local councils. Publication by local councils of procurement plans, notices of tenders and awards on notice boards.

4. Of course, the passing of legislation is but the first step; successful implementation thereof typically takes time to achieve.

5. The summary risk analysis is based on the project's proposed financial management arrangements.

Risk Assessment and Mitigation

Risk	Risk Rating	Risk Mitigating Measures incorporated into the Project Design	Conditions of Negotiations, Board or Effectiveness (Yes or No)	Remarks
Inherent Risk				
Country Level Weaknesses in legislative scrutiny, in the banking sector, as well as low human capacity.	H	Use of separate pre-existing project coordinating unit (for IRCBP) to support implementation and FM.	No	Using a pre-existing PCU of another project (IRCBP) for FM.
Entity Level Weak FM capacity at local council level.	H	Use of the Local Government Finance Department performing similar functions under the IRCBP	No	
Program Level Weak FM capacity.	S	Use of IRCBP Coordinating Unit which is headed by a professionally qualified Accountant to handle day to day financial management for MOHS as it is doing for GOSL.	No	
Control Risk				
Budgeting Coordinating the demands of two separate ministries could be a challenge.	S	Modify existing Operational Manual for the project to include clear guidelines on budgeting and budgetary control for district health teams.	Yes	Draft in place.
Accounting Government accounting system not yet been rolled out at local government level.	S	Will use the already established IRCBP FM systems and accounting procedure manuals.	No	Already in place.

Internal Control 1. Control procedures may not be adequate for a decentralized system of implementation 2. That management may override any existing controls	S	Use of IRCBP systems, including the Local Government Finance Department as appropriately modified to reflect the peculiarities of this project.	N	Already in place.
Funds Flow Delays in transfer of funds to especially rural recipients.	S	Simplified procedures through the Local Government Finance Department.	N	Already in place.
Financial Reporting Delays in producing and submitting IFRs	M	IRCBP Coordinating Unit will produce regular reports using existing templates, customized as appropriate.	Y	Agreement on IFR formats a condition for negotiation.
Auditing Difficulty in engaging a new auditor and attendant delays in presenting the audit report	M	Subject to the necessary procurement clearances, the TOR of the existing auditor could be amended to include the Designated Accounts with LGFD.	N	The finalization of the audit arrangements will be agreed at negotiations.
Overall Risk Rating	S			

Ratings: H – High; S – Substantial; M – Modest; N – Negligible

6. In view of the above risk management framework, the overall financial management risk for the project is rated **substantial.** The residual risk however is rated **moderate,** given the existence of a fully functional FM unit into which the project will tap from and when the various mitigating measures are implemented.

Strengths and Weaknesses

7. Weakness: The separation of duties between the Ministry of Health and Sanitation (MOHS), the Local Councils (LCs) and the Local Government Finance Department (LGFD) of the IRCBP presents implementation challenges. On the face of it, the arrangements appear complicated, but they can work, if the rules of engagement are clearly spelt out in the Operational Manual.

8. Strengths: The LGFD is already carrying out the same 'funds management' functions under IRCBP. This is advantageous to the project as all systems would be ready by the time the project becomes effective.

Staffing

9. The Finance Directorate of the IRCBP is fully staffed and has adequately qualified personnel. The head is a fully qualified Chartered Accountant, who is very familiar with Bank procedures. As stated above, MOF is already managing

similar IRCBP funds (i.e. the LGDGs) for Local Councils, through its Local Government Finance Department. Existing staffing levels should be adequate to cover the additional workload.

Budgeting

10. Budgeting is program driven, and fully integrated into the planning processes of the LCs. The Ministry of Health, through its District Health Management Teams (DHTMs), will monitor budget execution and take necessary steps to align actual achievements with approved plans.

Accounting

11. The IRCBP accounting is captured on the government IFMIS, although reporting is done using an electronic spreadsheet. Accounting will be based on standard double entry bookkeeping and will comply with international standards.

Internal Control

12. There is adequate segregation of duties within the project management structures of IRCBP. The Accounting and internal control procedures are codified in an existing Accounting Manual and is fully complied with for the ongoing project. Minor customization to the manual may be required, as part of the new Operational Manual for the phase 1 project, for any new elements covered by the new funding.

Internal Auditing

13. IRCBP does not have a formal Internal Audit Unit. Private auditors have from time to time provided periodic services. This arrangement will continue in addition to a strengthened internal control system supported by documented set of policies and procedures in a user friendly manual.

Financial Reporting

14. The project will produce interim un-audited financial reports (IFR) on a quarterly basis, using the standard format agreed for the ongoing projects at LGFD of the MOF under IRCBP. Formal adoption of these formats will be agreed at negotiations. The project will produce financial statements to be audited and the report thereof submitted to the Bank within six months after the end of phase 1, which is expected to be implemented over a six month period unless otherwise extended by agreement between the Bank and the recipient. The financial statements will comply with International Standards.

15. The LGFD will prepare quarterly IFRs in the areas of finance, procurement, including complaints from bidders, and project progress. The financial management system put in place should be capable of producing these reports. The IFRs include: Quarterly Financial Report, which would consist of a statement of cash receipts by sources and expenditures by main expenditure classifications for the period and cumulatively, cash balances of the Project, and

supporting schedules comparing actual and budgeted expenditures. The report should be submitted to the Bank within forty five (45) days of the end of the quarter.

External Audit

16. IRCBP already has an auditor in office with qualifications and attributes acceptable to the Bank. Subject to the necessary procurement clearances, the TOR of the existing auditor will be amended to include the Designated Accounts with LGFD. The TOR of the audit may include the audit of Local Council activities financed by the grant, on a rotational and selective basis[33]. Finalization of these audit arrangement will be brought to closure within the first three months of project effectiveness. However, every effort will be made to complete the audit arrangements prior to effectiveness of Phase 1. The audit report must be submitted to the Bank within six months of the end of phase 1, which is expected to be implemented over a six month period unless otherwise extended by agreement between the Bank and the recipient. A management letter highlighting any deficiencies in the system of management and internal controls should also be submitted as part of the audit package.

Action Plan

17. Confirm project audit arrangements

Financial covenants

18. Financial covenants will be as follows:

- Quarterly interim financial reports will be prepared and sent to the Bank no later than 45 days from the end of the quarter.
- Final audit reports will be prepared and submitted to the Bank within six months of the end of Phase 1 (Phase 1 will last for six months unless extended by agreement between the recipient and the Bank).

Supervision plan

19. Two supervision missions will be undertaken. These will be complimented by quarterly desk reviews of the IFRs.

Designated Accounts and funds flow

20. A USD denominated and segregated Designated Account will be opened with a commercial bank acceptable to the IDA. The Designated Account will be a revolving account to receive funds from ACGF Grant, disburse for eligible expenditure and used for the transfer funds to Local Councils. It will be managed by the LGFD, a department hosted and supervised by the

[33] Rotation means a risk based selected sample every year, such that each activity financed under the grant will be audited at least once in its lifetime

IRCBP. The transfer of funds provided by the Grant to the bank account of each beneficiary LC will be in accordance with the Operational Manual.

Disbursement Arrangements

21. The project will use the transaction based disbursement for phase 1, which will last for six months, of the program. The proceeds of the grant would be disbursed over a six month period. The project may be allowed to continue submitting withdrawal applications for a grace period of 4 months to facilitate the disbursement of grant proceeds for eligible expenditures incurred before the closing date of the Grant. The grace period will be explicitly indicated in the Disbursement Letter for the project.

22. The proceeds of the Grant will be allocated to Goods, Consultancy, Training and Un-allocated categories as detailed in the disbursement table below:

Disbursement Table

S. No.	Category Description	Allocation (US$)	% Eligibility
1	Goods	4,500,530.00	100
2	Consultancy and Training	944,095.00	100
3	Operating Costs	555,375.00	100
	Total	**6,000,000.00**	

Use of Statement of Expenditures

23. Disbursements for all expenditures would be against full documentation, except for items of expenditures under contracts and purchase orders estimated at US$250,000 equivalent or less for goods, US$100,000 equivalent or less for consultant services by firms, and US$50,000 equivalent or less for consultant services by individuals, training and operating costs for which disbursements would be based on statement of expenditures (SOEs). Supporting documentation for statement of expenditures would be retained by the IRCBP Coordination Unit for review by Bank missions and external auditors.

Retroactive Financing

24. The Grant will only finance eligible expenditures incurred after November 15th, 2007 not to exceed five hundred thousand United States dollars ($500,000).

Conclusions of the FM Assessments

25. The proposed FM arrangements for the phase 1 of the Reproduction and Child Health Project to be managed by the IRCBP meet the minimum requirements for financial management under OP/BP 10.02.

ANNEX 8: PROCUREMENT ARRANGEMENTS

SIERRA LEONE: Reproductive and Child Health Project

A. General

1. Procurement for the proposed project will be carried out in accordance with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits" dated May 2004, and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated May 2004, and the provisions stipulated in the Legal Agreement. The various items under different expenditure categories are described in general below. For each contract to be financed by the Grant, the different procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, prior review requirements, and time frame are agreed between the Recipient and the Bank project team in the Procurement Plan. The Procurement Plan will be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

2. **Procurement of Works:** No works contracts are anticipated under this project.

3. **Procurement of Goods:** Goods procured under this project would include, *inter alia*, vehicles, motorcycles, computers, essential drugs, medical supplies and equipment, and generators. The procurement will be done using the Bank's Standard Bidding Documents (SBD) for all International Competitive Bidding (ICB) and National SBD agreed upon with the Bank for all non ICB procurement. Domestic preference may be included in bidding documents for works and goods procured through ICB. Specific Procurement Notices (SPN) are mandatory for ICB and NCB procurement methods. Notifications for ICB will be published as a Special Procurement Notice in UN Development Business online, dgMarket and the local newspapers.

4. To the extent possible, goods that could be procured from one supplier would be grouped into contract packages, and packages estimated to cost the equivalent of 250,000 USD or more would be procured using ICB procedures. Procurement of goods packages estimated to cost more than 50,000 USD but less than 250,000 USD would be procured using National Competitive Bidding (NCB) procedures and Direct Contracting (DC) using IAPSO. Goods packages estimated to cost less than 50,000 USD would be procured by shopping on the basis of comparison of quotations from at least three eligible and qualified suppliers. Requests for such quotations will include a clear description and quantity of the goods, as well as requirements for delivery time and point of delivery.

5. **Procurement of non-consulting services:** None is expected under this project.

6. **Selection of Consultants:** Consulting firms will be required, *inter alia*, for project management, monitoring and evaluation, audits. Contracts for consulting services, each estimated to cost 100,000 USD equivalent or more, will be awarded following the procedure of Quality and Cost Based Selection (QCBS); and Procedure of Single-Source Selection (SSS) would be followed for assignments which meet the requirements of paragraphs 3.10-3.12 of the Consultant Guidelines and will always require the Bank's prior review regardless of the amount.

Consulting services estimated to cost less than 100,000 USD per contract under this project may be procured following the procedures of Selection Based on Consultants' Qualifications (CQS). Procedures of Selection of Individual Consultants (IC) would be followed for assignments which meet the requirements of paragraph 5.1 and 5.3 of the Consultant Guidelines. Least-Cost Selection (LCS) would be used for selecting the auditors. For all contracts to be awarded following QCBS, QBS, LCS and FBS, the Bank's Standard Request for Proposals will be used.

7. **Operating Costs:** incremental recurrent expenditures incurred by the local councils include maintenance of vehicles, fuel, equipment, office supplies, utilities, consumables, bank charges, advertising expenses, travel, per diems, and accommodation but excluding salaries of Recipient's civil service. They will be procured using the implementing agencies administrative procedures reviewed and found acceptable to the Association.

B. Assessment of the agency's capacity to implement procurement:

8. An assessment of the capacity of the IRCBP Coordinating Unit and the decentralized local councils to implement procurement actions for the project was carried out by the Procurement Specialist on the Project team in September 2007. The assessment reviewed the organizational structure for implementing the project and the interaction between the project's staff responsible for procurement and the Ministry's relevant units for administration and finance.

9. No key issues and risks concerning procurement during implementation of the project were identified at the level of the IRCBP Coordinating Unit (PCU) where the bulk of procurement will be carried out. At the local council level where the procurement will be limited to the Shopping method during this phase, key procurement officers have been trained and appointed.

10. The overall project risk for procurement is however moderate since the bulk (about 90%) of all procurement activities will be carried out by the Procurement Unit of the IRCBP in collaboration with the Procurement Unit of the Ministry of Health and Sanitation. Both units have collaborated throughout project preparation and together prepared the consolidated and individual local council procurement plans. Bids for procurement of vehicles were opened on 20 September 2007 and bidding documents for essential drugs, medical supplies and equipment etc. will be available for IDA review by end December 2007[w2]. At the local council level, where procurement will be mainly through the shopping method, the corrective measures which have been agreed are the appointment of the already trained procurement officers and their mentoring by the IRCBP Procurement Specialist.

Procurement Plan

11. The Recipient, at appraisal, developed a procurement plan for project implementation which provided the basis for the procurement methods. This was agreed between the Recipient and the Project Team. The final procurement plan will be available in the project's database and in the Bank's external website. The Procurement Plan will be updated in agreement with the

Project Team as required to reflect the actual project implementation needs and improvements in institutional capacity.

D. Frequency of Procurement Supervision

12. In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agencies has recommended two supervision missions to visit the field to carry out post review. Follow-up on the implementation of the action plan for the improvement of procurement capacity in the local councils will be part of all supervision missions.

E. Details of the Procurement Arrangements Involving International Competition

13. **1. Goods and Non Consulting Services**

(a) List of contract packages to be procured following ICB and direct contracting:

1	2	3	4	5	6	7
Contract (Description)	**Estimated Cost (US$)**	**Procurement Method**	**Pre-qualification**	**Domestic Preference (yes/no)**	**Review by Bank (Prior / Post)**	**Expected Bid-Opening Date**
Vehicles	730,000	ICB	NO	YES	PRIOR	20 Sept 07
Motorcycles and Bicycles	1,200,000	ICB	NO	YES	PRIOR	15 Nov 07
Essential Drugs	500,000	ICB	NO	YES	PRIOR	15 Nov 07
Medical Supplies and Equipment	520,000	ICB	NO	YES	PRIOR	19 Nov 07
Outreach Packages	250,000	ICB	NO	YES	PRIOR	19 Nov 07

(b) ICB contracts estimated to cost above $250,000 per contract and all direct contracting will be subject to prior review by the Bank.

2. Consulting Services

(b) Consultancy services estimated to cost above 100,000 USD (firms) and 50,000 USD per contract (individuals) and all single source selection of consultants (firms and individuals), regardless of the amount, will be subject to prior review by the Bank.

(c) **Short lists composed entirely of national consultants:** Short lists of consultants for services estimated to cost less than 100,000 USD equivalents per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

ANNEX 9: ECONOMIC AND FINANCIAL ANALYSIS

SIERRA LEONE: Reproductive and Child Health Project

1. Economic Analysis: The selection of project activities is based on their proven cost-effectiveness and ease of scaling up. Table 1 shows the expected impact on the U5MR for each intervention.

Table 1: List of the Cost Effective Interventions in Lancet Child and Neonatal Series

Interventions	Efficacy	Cost Effectiveness (%)	Impact on Under 5 Mortality
Vaccination	>80%	12- 17	20%
Insecticide Treated Nets	50%	16-43	20-25%
Supplementation Vitamin A	>80%	4	20%
IPT infant	25%?		
Integrated Management of Childhood Illness Plus		30- 50	50%
Anti-malarial	>80%	13	15%
Insecticide Treated Nets	50%	16- 43	20-25%
Treatment for Acute Respiratory Infection	>80%	20- 50	15%
Oral Rehydration	>80%	25- 75	15%
Exclusive Breastfeeding	25%	25- 30	10%
Hygiene	25%	20	10% of diarrhoea
ANC Plus		30-50	12%
Tetanus vaccine	>80%	12- 17	3%
IPT in pregnancy	25%?	4- 49	4%

2. Phases 2 and 3: The economic and financial analyses for the ten year program will be completed as part of the MBB exercise at the regional level. The final MBB exercise will provide the following economic and financial information:

- ② Incremental cost of management and technical support
- ② Incremental cost of services + management and technical support
- ② Incremental cost in % to Government heath expenditure per capita per year
- ② Incremental cost in % to total heath expenditure per capita per year
- ② Incremental cost in % fiscal space
- ② Estimated Cost per life saved by component
- ② Additional Cost per life saved

3. Financial Analysis: The project will increase the available budget for LCs for 2007 by approximately 18 percent from US$0.67 to US$0.86. This is equal to an additional US$1 for each child under the age of 5. With committed donor funding for the next ten years, this amount should be sustainable.

Table 2: 2007 District Budget and Additional Financing (USD)

District/Local Council	Total Population*	Estimated population under 5*	2007 budget per capita	Project financing per capita	% change in 2007 budget per capita	Project financing per child under 5
Bo District	557,605	93,697	0.68	0.19	**16.8**	1.11
Bombali District	413,147	72,745	0.85	0.21	**17.6**	1.20
Bonthe District	140,899	29,284	0.69	0.32	**20.8**	1.52
Kailahun District	391,895	74,288	0.73	0.2	**19.0**	1.06
Kambia	286,953	58,674	0.63	0.22	**20.4**	1.10
Kenema District	551,800	97,541	0.73	0.18	**17.7**	1.01
Koinadugu District	281,701	48,898	0.58	0.29	**17.4**	1.68
Kono District	263,902	47,199	0.83	0.27	**17.9**	1.52
Moyamba District	228,588	43,955	1.71	0.22	**19.2**	1.15
Port Loko District	467,000	91,153	0.8	0.19	**19.5**	0.95
Pujehun District	287,200	57,892	0.68	0.22	**20.2**	1.11
Tonkolili District	364,873	71,845	0.42	0.19	**19.7**	0.95
Western Rural	226,440	40,766	0.47	0.11	**18.0**	0.63
Western Urban	881,197	117,235	0.31	0.08	**13.3**	0.63
Sierra Leone	**5,343,200**	**952,586**	**0.67**	**0.19**	**17.8**	**1.05**

ANNEX 10: SAFEGUARD POLICY ISSUES

SIERRA LEONE: Reproductive and Child Health Project

1. The Project is using the updated Environmental Management Plan of the recently approved Additional Financing for the Health Sector Reconstruction and Development Project, which was submitted to the Bank and disclosed in-country on October 1, 2007, and submitted to the World Bank's Infoshop on October 1, 2007.

2. The project is unlikely to generate any potential large scale, significant and/or irreversible impacts since it will focus on delivering health care service and capacity building in all 14 districts in Sierra Leone. It will not involve any construction work and interventions that could result in land take or destruction of natural habitats, forests or cultural resources. However, improper handling of ITNs and medical supplies could result in medical waste management challenges including misuse of chlorine in the treatment of water wells.

3. The Government is currently implementing the Environmental Management Plan. The Environmental and Sanitation Unit (ESU) of the Ministry of Health and Sanitation ensures that all health facilities in the country manage health care waste in full compliance with this plan. The ESU has received sufficient training and skills upgrade to monitor compliance and act as trainers of trainees.

4. The activities that have so far been implemented under the Environmental Management Plan include:

- Development of Policy on Medical Waste Management is under the Environmental Management Plan.
- Training of three District Medical Officers (DMO) and two Environmental Health Officers (EHO) as trainers of Medical Waste Management and prevention of nosocomial infections.
- Designation of one trained EHO per District as District Medical Waste Management Officer (Program Focal Point).
- Development and distribution of guidelines for Medical Waste Management of Sierra Leone.
- Development by a technical assistance of the De Mont Fort Incinerator in Sierra Leone.
- Training of NGOs, public, private and paramedical health care staff countrywide on medical waste management.
- Training of technicians to operate medical waste management equipment in health care facilities.

ANNEX 11: PROJECT PREPARATION AND SUPERVISION

SIERRA LEONE: Reproductive and Child Health Project

	Planned	Actual
PCN review	04/06	11/06
Quality Enhancement Review	11/06	11/06
Initial Project Information Document to Public Information Center		
Initial Integrated Safeguards Datasheet to Public Information Center	05/07	05/07
Appraisal	08/07	08/07
Negotiations	10/07	11/07
Regional Vice President approval	10/07	11/07
Planned date of effectiveness	10/07	12/07
Planned date of mid-term review	n/a	
Planned closing date	04/08	06/08

Key institutions responsible for preparation of the project: MOHS, IRCBP

Bank staff and consultants who worked on the project included:

Name	Title	Unit
Laura Rose	Task Team Leader	AFTH2
Johanne Angers	Operations Officer	AFTH2
Tsri Apronti	Procurement Specialist	AFTPC
Samuel Bruce-Smith	Consultant	AFTFM
Manush Hristov	Counsel	LEGAF
Evelyn Awittor	Operations Officer	AFTH2
Edward Dwumfour	Senior Environmental Specialist	AFTS4
Yongmei Zhou	Senior Economist	AFTPR
Gregoria Dawson-Amoah	Program Assistant	AFCW1
Mawutor Aku-Sika Akoto	Team Assistant	AFCW1
Gillian Edworthy	Consultant (Intern)	AFTH2

Bank funds expended to date on project preparation:

1. Bank resources: $20,000 (variable costs covered by on-going health project prior to approval of ACGF)
2. ACGF: $85,000 (variable costs only)
3. Total: $105,000

Estimated Approval and Supervision variable costs: Phase I - $30,000; Phase II - $75,000

ANNEX 12: DOCUMENTS IN THE PROJECT FILE

SIERRA LEONE: Reproductive and Child Health Project

Child Survival and Maternal Mortality Reduction in Sierra Leone: A Situational Analysis. June 2006. MOHS/UNICEF

Monitoring the Situation of Children and Women: Findings from the Sierra Leone Multiple Cluster Survey 2005. Preliminary Report. August 2006. Statistics Sierra Leone and UNICEF.

Comprehensive Local Government Performance Assessment System (CLoGPAS) in Sierra Leone. Round 1 Field Instruments, November 2006. IRCBP.

A Strategic Framework for Reaching the Millennium Development Goal on Child Survival in Africa. September 2006. Africa Union

Sierra Leone 2007 District Health Plans and training Plans

Primary Healthcare in Sierra Leone: Clinic Resources and Perceptions of Policy after One Year of Decentralization. June 2007. IRCBP Evaluations Unit.

A User Guide for the Marginal Budgeting for Bottleneck Toolkit: An Analytical Costing, Planning and Budgeting Toolkit for Evidence-based Results-oriented Health Service Management in Developing Countries. August 2006. UNICEF/World Bank

ANNEX 13: STATEMENT OF LOANS AND CREDITS

SIERRA LEONE: Reproductive and Child Health Project

CAS Annex B8 - Sierra Leone

Operations Portfolio (IBRD/IDA and Grants)

As Of Date 08/07/2007

Closed Projects 32

IBRD/IDA *

Total Disbursed (A	114.57
of which has	0.00
Total Disbursed (C	592.33
of which has	75.48
Total Disbursed (A	686.90
of which has	75.48
Total Undisbursed	141.18
Total Undisbursed	0.00
Total Undisbursed	141.18

Active Projects

Project ID	Project Name	Last PSR Supervision Rating: Development Objectives	Last PSR Supervision Rating: Implementation Progress	Fiscal Year	Original Amount in US$ Millions: IBRD	IDA	GRANT	Cancel.	Undisb.	Difference Between Expected and Actual Disbursements: Orig.	Frm Rev'd
P074320	SL-Basic Edu Rehab (FY03)	S	S	2003		20			7.199721	4.6757176	
P086801	SL-Burrbuna Env. and Social SIL (FY05)	MU	MU	2005		12.5			8.373689	6.0540628	-0.345937
P073883	SL-HIV/AIDS Response (FY02)	MS	MS	2002		15			1.273965	-1.561803	-1.561803
P074128	SL-Health Sec Reconstr & Dev (FY03)	S	S	2003		28			12.54684	1.886989	
P078369	SL-IDP Transp (FY06)	S	S	2006		44			43.62974	9.1627456	5.164095
P078613	SL-Inst Reform & Cap Bldg TAL (FY04)	S	S	2004		25.12			4.464611	0.6231331	
P079335	SL-Natl Scc Action (FY03)	MS	S	2003		35			5.42668	2.6855561	-3.315
P087203	SL-Power & Water SIL (FY05)	U	U	2005		35			28.10579	18.123113	
P086105	SL-Rural Dev & Priv Sec Dev SIL	#	#	2007		30			30.15984		
Overall Result						244.62			141.1798	41.648494	-0.058645

SIERRA LEONE
STATEMENT OF IFC's
Held and Disbursed Portfolio
In Millions of US Dollars

Sierra Leone
Statement of IFC's
Held and Disbursed Portfolio

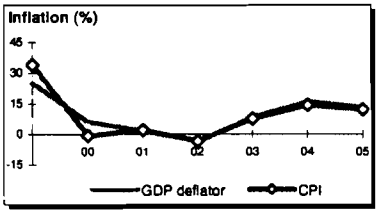
(In US Dollars Millions)

			Held				Disbursed			
FY Approval	Company	Loan	Equity	Quasi	Partic	Loan	Equity	Quasi	Partic

Approvals Pending Commitment				
Loan	Equity	Quasi	Partic

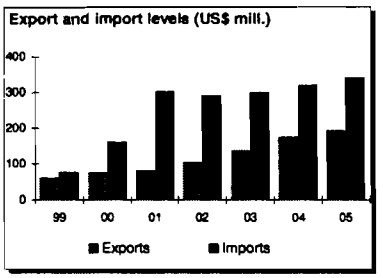
PRICES and GOVERNMENT FINANCE

	1985	1995	2004	2005
Domestic prices				
(% change)				
Consumer prices	76.6	26.0	14.2	12.1
Implicit GDP deflator	68.9	33.6	16.0	13.1
Government finance				
(% of GDP, includes current grants)				
Current revenue	7.3	9.5	21.3	21.3
Current budget balance	-14.4	-7.2	1.1	2.7
Overall surplus/deficit	-21.7	-9.8	-3.5	-4.7



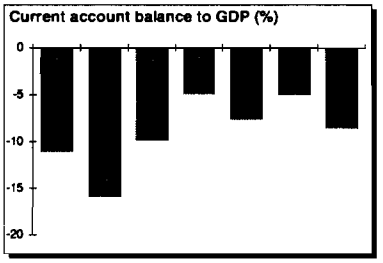
TRADE

	1985	1995	2004	2005
(US$ millions)				
Total exports (fob)	127	102	174	192
Commodity 1	..	..	..	..
Commodity 2	..	..	..	..
Manufactures	..	..	..	..
Total imports (cif)	165	137	319	340
Food	52	66	57	52
Fuel and energy	23	24	42	45
Capital goods	38	11	33	37
Export price index *(2000=100)*	..	116	107	104
Import price index *(2000=100)*	..	108	99	100
Terms of trade *(2000=100)*	..	107	108	104



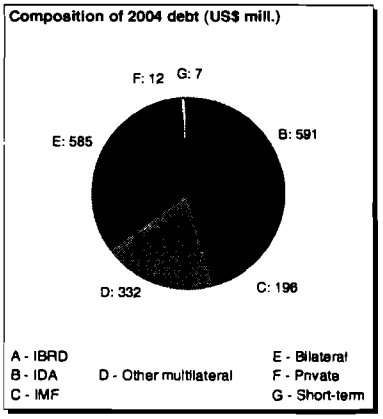
BALANCE of PAYMENTS

	1985	1995	2004	2005
(US$ millions)				
Exports of goods and services	180	162	239	287
Imports of goods and services	208	231	406	509
Resource balance	-28	-68	-167	-223
Net income	-29	-24	-32	-32
Net current transfers	16	42	146	152
Current account balance	-41	-50	-53	-102
Financing items (net)	39	49	101	87
Changes in net reserves	2	1	-48	15
Memo:				
Reserves including gold *(US$ millions)*	11	35	82	112
Conversion rate *(DEC, local/US$)*	5.1	755.2	2,701.3	2,950.0



EXTERNAL DEBT and RESOURCE FLOWS

	1985	1995	2004	2005
(US$ millions)				
Total debt outstanding and disbursed	711	1,250	1,723	..
IBRD	9	3	0	0
IDA	59	231	591	559
Total debt service	24	83	27	..
IBRD	1	1	0	0
IDA	1	3	3	13
Composition of net resource flows				
Official grants	72	87	261	..
Official creditors	20	67	68	..
Private creditors	-4	-28	0	..
Foreign direct investment (net inflows)	-31	7	26	..
Portfolio equity (net inflows)	0	0	0	..
World Bank program				
Commitments	0	36	35	..
Disbursements	9	44	31	19
Principal repayments	1	2	0	8
Net flows	9	42	31	10
Interest payments	1	2	3	5
Net transfers	8	40	27	6



Note: This table was produced from the Development Economics LDB database. 8/13/06

ANNEX 15: MODEL OF A SUB-GRANT AGREEMENT WITH A LOCAL COUNCIL

SIERRA LEONE: Reproductive and Child Health Project

2007 Health Plan Sub-Grant Agreement

An Agreement between the Ministry of Finance and the ..... Council (hereinafter referred to as the Council dated ..... 200..... relating to the financing of the Phase 1 District Health Plan attached to this Agreement (hereinafter referred to as the Plan) under the Reproductive and Child Health Project (hereinafter referred to as the Project) financed by the Africa Catalytic Growth Fund and administered by the World Bank.

Value of Grant:

The Ministry of Finance agrees to transfer to the Council, a grant in the amount of ..... Leones for the implementation of the attached Plan for the period .....

Obligations of the Government of Sierra Leone:

Frequency and mode of payments: The total outstanding payments for all activities under the Plan will be made as a one-off payment directly into the Health Bank Account of the Council opened for the purpose of the Project at a date to be determined by the Financial Secretary, Ministry of Finance.

Procurement: Under this sub-grant, procurement will follow guidelines and procedures as described in the project operational manaual.

Obligations of the Council

Service delivery obligations:

- To spend the grant for the carrying out of the activities and eligible expenditures as presented in the attached Plan, in such amounts as specified in the Plan and in the total value of the grant above;
- To act with due diligence and efficiency and in accordance with sound technical, financial, managerial and environmental standards and practices in carrying out the Plan;
- To implement activities that may not have a potential negative environmental or social impact, and that such activities are conformed to the Ministry of Health and Sanitation Environmental Management Plan, by means of which the potential negative environmental/social impact of the proposed Plan can be mitigated;

- To maintain adequate records of all activities and expenditures financed through the grant;
- To promptly inform the Ministry of Finance of any material changes in its circumstances that is likely to interfere or threaten to interfere with the progress of the Plan or the ability of the Council to implement the plan.

Information provision obligations:

- The Council will submit to the Local Government Finance Department (LGFD) of the Ministry of Finance a written report no later than four months after the signing of this Agreement, and subsequently 30 days after the end of every quarter showing that the grant has been spent for the carrying out of the activities and the financing of the eligible expenditures as specified in the attached agreed Plan;
- The Council will provide the Ministry of Finance or its authorized representatives, the Ministry of Local Government and Community Development, the Ministry of Health and Sanitation, and the World Bank, unhindered access to goods, works, sites, plants, records and documents relating to the implementation of the Plans for the purposes of inspection;

Consequences of default by Council

The Council further agrees that the Ministry of Finance:

1. retains the right to suspend all funding for the purpose of the Plan under the Project if it has evidence that the Council has failed to perform their obligations under this agreement, until the Council can demonstrate their conformity with this agreement;

2. will, where the Project funds are utilized for any purpose other than the purposes for which funding was provided, obtain a refund of all misused funds and/or suspend all prospective Plan funding to the Council until the Council completes the activity that is the subject of misapplication of funds, from its own revenue sources; and

3. Where the council's funding is suspended for reasons of default, the LGFD will make this public by placing a notice on the council's notice boards and by public statements on radio and in newspapers.

MAP SECTION