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

Report No.: PIDISDSA16026

Date Prepared/Updated: 07-Mar-2016

I. BASIC INFORMATION

A. Basic Project Data

Country:	Sierra Leone	**Project ID:**	P153064
		Parent Project ID (if any):	
Project Name:	Health Service Delivery & System Support Project (P153064)		
Region:	AFRICA		
Estimated Appraisal Date:	29-Feb-2016	**Estimated Board Date:**	20-Jun-2016
Practice Area (Lead):	Health, Nutrition & Population	**Lending Instrument:**	Investment Project Financing
Sector(s):	Health (50%), Other social services (50%)		
Theme(s):	Health system performance (50%), Population and reproductive health (35%), Other human development (10%), Child health (5%)		
Borrower(s):	Ministry of Finance and Economic Development		
Implementing Agency:	Ministry of Health and Sanitation		

Financing (in USD Million)

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	10.00
Ebola Recovery and Reconstruction MPF	5.00
Total Project Cost	15.00

Environmental Category:	B - Partial Assessment
Appraisal Review Decision (from Decision Note):	The review did authorize the team to appraise and negotiate
Other Decision:	
Is this a Repeater project?	No

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B. Introduction and Context

Country Context

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

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

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

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

Further, data from the first round of the High Frequency Cell Phone surveys, conducted in November 2014, suggests declines in employment, high food insecurity, and reduced utilization of services which have the potential to negatively affect both short and long-term household well-being. While the survey found no significant impact on small holder agriculture, there were large effects on household enterprises and significant declines in employment in urban areas (7 percentage points), particularly among the non-farm self-employed. Youth are especially

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vulnerable, with the employment rate among youth in some urban areas declining more steeply than among workers overall and youth in rural areas experiencing a larger drop in hours worked. Female-headed households are also particularly vulnerable as they are disproportionately working in the hard-hit non-farm self-employment sector.

Sectoral and institutional Context

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

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

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

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

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

Physical and financial access to primary health care is limited, despite the Government’s Free Health Care Initiative. The DHS 2013 found that 38 percent of women interviewed (over 50 percent in rural areas) had issues with distance and transportation and 67 percent stated that cost

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was a serious problem. Service readiness is generally low, as most facilities lack the trained staff and equipment required to provide those services they are supposed to deliver. End-users also complained of the quality of services (staff absenteeism and attitudes, drug stock-outs, illegal fees, etc.). However, Sierra Leone lacks effective structures allowing patients to channel their complaints and grievances about the health care system.

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

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

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

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C. Proposed Development Objective(s)

Development Objective(s)

The project development objective (PDO) of the Health Service Delivery and System Support Project is to increase the utilization and improve the quality of essential maternal and child health services in selected districts.

Key Results

Key outcome and intermediate outcome indicators have been selected to measure the achievement of the project development objective and component results. Three outcome indicators will measure utilization, and three will measure quality. In addition, the project will monitor core sector indicators including measuring the number of direct beneficiaries. The project indicators are presented below:

Utilization
- Number of outpatient visits per 10,000 population
- Percentage of pregnant women attended 4 or more times by any health personnel
- Percentage of births attended by skilled health personnel

Quality
- Percentage of pregnant women receiving 2+ TT
- Percentage of children (0-11 mos.) fully vaccinated
- Number of maternal deaths recorded at community, PHU, and hospital levels

Beneficiaries
- Direct project beneficiaries (number), of which female (percentage) and children 0-11 months (number).

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D. Project Description

To date, the Bank-financed EERP has provided support to Sierra Leone’s Post Ebola Recovery. The proposed Health Service Delivery and System Support Project (HSDSSP) is designed to: (i) maintain the momentum of support provided by the EERP; and (ii) contribute to the flagship programs proposed by MoHS’s Health Sector Recovery Plan. The project will also be complementary to: (i) ongoing support by the Development Partners in Sierra Leone to the post Ebola recovery efforts; and (ii) the Regional Disease Surveillance and System Enhancement Project (REDISSE).

Responding to the President’s directive to improve maternal and child health outcomes, which remain among the worst in the world and the the PDO is aligned to this. The proposed lending instrument is Investment Project Financing (IPF). The US$35 million equivalent cost of the Project will be financed by an IDA credit of US$30 million equivalent and an ERRTF grant of US $5 million. The project will be implemented over a 3.5 year period (April 2016-December 2018).

Component Name

Health Service Delivery

Comments (optional)

This component will contribute to improving service delivery and restoring the confidence of the

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project beneficiaries in the public sector provision of health care services. Two sub-components are planned: (i) to strengthen community level engagement; and (ii) to enhance facility-level services and ensure emergency transport, especially for pregnant women, from communities and PHUs to the Distri

Component Name

Health System Support

Comments (optional)

This component will contribute to the development of longer-term efforts to address the issues of health human resources and sector management and coordination. Three sub-components are planned: (i) to initiate the development of critical cadres of health human resources to strengthen service delivery at the PHU and district hospital level; (ii) to improve the oversight and management performance

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

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

F. Environmental and Social Safeguards Specialists

Michael Gboyega Ilesanmi (GSU01)

Ruma Tavorath (GEN07)

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II. Implementation

Institutional and Implementation Arrangements

Recovery planning is coordinated centrally by the Presidential Delivery Unit (PDU) and the sectoral Ministries. For the health sector, the Minister of Health oversees the planning process and implementation of the recovery phase of the Ministry’s post-Ebola Health Sector Recovery Plan (2015-2020). The Minister is supported by a dedicated delivery unit headed by the Office of the Chief Medical Officer (CMO) and in collaboration with the Health Sector Coordinating Committee (HSCC) and the Flagship Forum. The HSCC is chaired by the Minister and includes the Heads of Agencies of development partners supporting the health sector.

The Flagship Forum was established to take stock of progress in reaching the milestones for each of the Flagship programs under the 10-24 Months Recovery Plan. The Forum comprises the Minister and Deputy Ministers, the CMO and the two Deputy CMOs, the Chief Nursing Officer (CNO), and

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the Directors of the Directorates responsible for the Flagship Programs supported by the project.

In addition: (i) a Transition Working Group has been created to facilitate the transition process between Ebola Response and post-Ebola Recovery and across different Recovery phases; and (ii) a Health System Strengthening Hub under the Directorate of Health System Policy Planning and Information has been established to coordinate the development of the National Health Sector Policy 2015-2020.

The project will be implemented by MoHS under the leadership of the Project Steering Committee. The Steering Committee will comprise: (i) the Chief Medical Officer (CMO), who will serve as Project Director and provide overall technical guidance and oversight; and (ii) .the Directorates involved in project implementation. The CMO will work closely with MoFED and Local Government authorities at central and district levels to ensure cohesion between the planned flagship initiatives and their district implementation.

Each of the sub-components will be assigned to the appropriate directorates, which will have technical implementation responsibilities. A more detailed description of the arrangements by sub-component is presented in Annex 3. The IHPAU will provide fiduciary support to the proposed project as well as to other donor supported projects in the health sector. IHPAU specialists will comprise: fund management; financial management; procurement; audit specialist; and monitoring, evaluation, accountability, and learning.

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III. Safeguard Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Impacts are expected from the provision of medical services. Since the mitigation measures of these activities are well-defined & understood & manageable, the project is rated as category B. Potential environmental impacts include safety of workers and access ofpatients and community to services etc. An ESMF/Healthcare waste management framework has beeen prepared to provide mitigation for potential impacts.
Natural Habitats OP/BP 4.04	No	Project activities are not expected to affect natural habitats.
Forests OP/BP 4.36	No	Project activities will not intrude upon and will not have any impacts on forest areas.
Pest Management OP 4.09	No	Project activities are not expected to procure or utilize pesticides or insecticides.
Physical Cultural Resources OP/BP 4.11	No	Project activities will not be undertaken on new land where there is possibility of presence of PCR.
Indigenous Peoples OP/BP 4.10	No	There are no Indigenous Peoples in the project area.
Involuntary Resettlement OP/BP 4.12	No	The project will not involve rehabilitation & new constructions.

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Safety of Dams OP/BP 4.37	No	Project activities will not entail construction of dams, nor rely on dams.
Projects on International Waterways OP/BP 7.50	No	Project activities do not have any impact on international waterways.
Projects in Disputed Areas OP/ BP 7.60	No	There are no project activities in any disputed areas.

IV. Key Safeguard Policy Issues and Their Management

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The project triggers the Environmental Assessment Policy OP 4.01 and the project is classified as Category B for environmental screening purposes given the modest risks associated with the handling and disposal of medical and general health waste. Possible environmental risks include the inappropriate handling and disposal of hazardous medical waste, including sharp needles, and especially the inadequate management of disposal sites in urban or peri-urban areas, where domestic and medical waste may be mixed and where scavenging is common. The project scope was changed recently to exclude civil works and constructions which are to be financed under an ongoing project. The Government prepared an ESMF to address these but it also includes a HCWMP to provide mitigation for potential impacts and will be used to guide project implementation activities.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

See above

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

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4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

The Government has finalized the ESMF which includes a HCWMP. Since only sub-projects with minor impacts are eligible, these are easily mitigated through the application of sensible site selection criteria, good construction practices and diligent management practices in the operational phase. This may include proper silting of infrastructure to avoid and minimize impacts, construction contract procedures for dealing with “chance finds,” control of dust generation and prevention, waste management and technology for toilet facilities like leaching fields, organic composting, and septic tanks.

The Borrower has sufficient institutional capacity to meet the safeguards requirements. Under the closed and ongoing Bank-financed Reproductive and Child Health Project Phases 1 and 2, several categories of staff were trained in medical waste management. These included district medical officers and environmental health officers. In addition, NGOs and some public, private and paramedical health care staff were trained in medical waste management. Technicians were also trained on how to operate medical waste management equipment and guidelines were distributed for medical waste management.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure

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on safeguard policies, with an emphasis on potentially affected people.
The key stakeholders include pregnant and lactating women and children under two years of age, healthcare workers, the donor community, the implementing Ministries and related government agencies involved in reproductive and child health services. The ESMF were publicly consulted on and will be disclosed in-country (and globally through the World Bank Info Shop) in a form and language appropriate for public comprehension prior to its finalization. All comments provided during the in-country consultations were recorded, and included in the final ESMF and any subsequent safeguard instruments which will be developed as required. Should the project implementers be required to develop a stand-alone environmental review or social assessment, an Indigenous Peoples Plan (IPP), or a Process Framework (PF), these documents will be disclosed to local communities in a form, manner and language appropriate for the local context. Disclosure will occur in two phases: • Disclosure of assessment documents (e.g. social assessment and environmental review) and draft safeguard documents (e.g. IPP and PF) during project preparation and prior to final review and approval of the sub-project proposal. Disclosure during sub-project preparation aims to seek feedback and input from local communities, and as appropriate other stakeholders, on the sub-project proposal and safeguard measures and documents. • Disclosure of final safeguard documents prior to sub-project implementation to inform local communities of implementation measures concerning safeguard issues. The project will disclose information of approved sub-projects, including any safeguard issues, through consultation meeting and validation meeting. Stakeholders can inquire further documentation and raise their concerns or recommendations to the Document.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	29-Jan-2016
Date of submission to InfoShop	07-Mar-2016
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	
"In country" Disclosure	
Sierra Leone	06-Apr-2016
Comments:	
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/ Audit/or EMP.	
If in-country disclosure of any of the above documents is not expected, please explain why:	

C. Compliance Monitoring Indicators at the Corporate Level

OP/BP/GP 4.01 - Environment Assessment	
Does the project require a stand-alone EA (including EMP) report?	Yes [×] No [ ] NA [ ]

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If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?	Yes [×] No [ ] NA [ ]
Are the cost and the accountabilities for the EMP incorporated in the credit/loan?	Yes [×] No [ ] NA [ ]
The World Bank Policy on Disclosure of Information	
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes [×] No [ ] NA [ ]
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?	Yes [ ] No [×] NA [ ]
All Safeguard Policies	
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have costs related to safeguard policy measures been included in the project cost?	Yes [×] No [ ] NA [ ]
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes [×] No [ ] NA [ ]

V. Contact point

World Bank

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Borrower/Client/Recipient

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Implementing Agencies

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VI. For more information contact:

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VII. Approval

Task Team Leader(s):	Name: Francisca Ayodeji Akala	
Approved By		
Safeguards Advisor:	Name: Johanna van Tilburg (SA)	Date: 15-Mar-2016
Practice Manager/ Manager:	Name: Trina S. Haque (PMGR)	Date: 15-Mar-2016
Country Director:	Name: Sergiy V. Kulyk (CD)	Date: 15-Mar-2016

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