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| Project Name | SIERRA LEONE-HEALTH SECTOR RECONST.(@)... & DEVELOP. |
| Region | Africa Regional Office |
| Sector | Health (100%) |
| Project ID | P074128 |
| Borrower(s) | GOVERNMENT OF SIERRA LEONE |
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1. Country and Sector Background

At the end of a decade of war, political and social instability, and deterioration of the economic performance of an otherwise well-endowed country, the health sector in Sierra Leone is facing many issues.

a) The health status of the population is, compared with other SSA countries, critical; it is estimated that life expectancy at birth is only 43 years, and infant, under-five and maternal mortality rates are as high as 170, 286 and 18 per 1000 live births respectively. The country is plagued by diseases for which cost-effective interventions are available but are not being used due to: (i) problems with resources of all kinds (financial, infrastructure and especially human resources); (ii) weak sector capacity, and; (iii) limited access to some geographical areas because of the security situation (until very recently), poor roads and inadequate communications. Among these diseases are malaria, tuberculosis, leprosy, acute respiratory diseases, diarrhea, Lassa fever, onchocerciasis, and cholera and other water borne diseases. Also, compared with neighboring countries, the HIV/AIDS epidemic is more significant; the prevalence rate of HIV sero-positivity is now estimated at about 4.9% (the CDC Atlanta base line survey of 2002) and may reach 18% in some groups (e.g., military). As a result of war atrocities, the country was left with thousands of amputees; a huge number of 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. Fertility rates are also high as a result of insufficient use of contraception, particularly in rural areas. Lastly, malnutrition is widely spread among children and lactating mothers and contributes significantly to the high mortality rates cited above.

b) The health delivery system is operating poorly. During the conflict, the country is estimated to have lost more than 50% of health facilities and the remaining facilities need rehabilitating, re-equipping, new staff, and technical and financial support. While the recent conflict exacerbated the situation by destroying health facilities and displacing (or worse) staff, the public health sector has not performed well for more than a decade; with inadequate financing, MOHS could not supervise and support technically the public health facilities country-wide. Further, the destruction of the infrastructure of other sectors affected, and continues to affect, the health sector's operations since communications, transport, electricity, water supply, etc., were also severely disrupted.

Many international and local NGOs specialized in providing health care during conflict and in post-conflict situations have successfully delivered services to the districts in which the public health facilities were not able to operate. In addition, NGOs are contributing substantially to alleviating psychological suffering and providing physical rehabilitation to amputees. As a result of the progress in peace negotiations and increased security, these NGOs are now in the process of phasing out their aid programs. Other NGOs (and particularly the religious NGOs), which had previously played an important role in the delivery of health care in rural areas, suffered severe damage in the war (of 47 mission facilities in operation before the 1997 coup, only 20 are currently functioning), the mission hospitals have lost their expatriate medical staff, and the current free drug policy (applied in some government facilities and by the large international NGOs) is drawing patients away from their clinics which continue to use cost recovery (and to also successfully exempt the poor from it).

The private for profit health system, although recently developing, remains weak and limited to the Western Region and the capital city.

This makes restoration of a functioning public health sector a crucial priority for the country. At present the most important challenges for the public health sector are to find solutions for:

(a) the lack of infrastructure, especially in the districts most affected by war;
(b) the limited administrative capacity of the public sector and its persistent inefficiencies;
(c) the lack of human resources (resulting from (i) staff attrition, (ii) inadequate training (undergraduate, postgraduate and continuous on the job training), (iii) emigration of medical doctors (in particular, of specialized physicians) to developed countries; (iv) distorted geographical distribution of health workers (during the war the health providers left the unsafe zones and came to work in Freetown); and the lack of skill and motivation of the remaining health personnel.
(d) the lack of capacity of the private for profit health sector and its inability (or unwillingness) to address major public health problems.

Health Status Indicators
Source of data: MICS 2 Survey 2000

| Indicators | Latest estimated value |
|---|---|
| Infant mortality rate | 170 per 1000 live births |
| Under-five mortality rate | 286 per 1000 live births |
| Maternal mortality rate | 1800 per 100,000 live births |
| Underweight prevalence in children under 5 years of age | 27.2% |
| Stunting prevalence in children under 5 years of age | 33.9% |
| Wasting prevalence in children under 5 years of age | 9.8% |
| Population with access to safe drinking water | 54.0% |
| Population with access to safe excreta disposal means | 63.1% |
| Antenatal care | 68.0% of pregnant women received at least one consultation |
| Deliveries attended by skilled personnel | 41.7% |
| Contraceptive prevalence rate (modern contraception) | 3.9% |
| Births weight below 2.5 Kg | 52.5% |
| Iodized salt consumption | 23.4% of households |
| Children receiving vitamin A supplementation | 58.2% |
| Mothers receiving vitamin A supplementation | 32.6% |
| Breast feeding (exclusive of other foods) of children under 4 months of age | 2.4% |
| Complementary feeding of children aged 4 to 9 months | 52.5% of children 4-9 months old are receiving breast milk and complementary food |
| Immunization rates in children 12 to 23 months of age | DPT: 45.5%; measles: 61.7%; TB: 61,2% and polio:72.8% |
| Neonatal tetanus immunization of pregnant women | 57.7% |
| Use of Oral Rehidration Therapy | 86.1% |
| Acute respiratory infections treated | 50.2% |
| Impregnated bednets used by children under 5 years of age | 1.5% |
| Malaria treatment in children under 5 years of age | 60.9% |
| Knowledge on HIV/AIDS prevention and misconceptions | 21.1% and 19.0% |

Data quality is affected by sample size and sampling techniques limitations. For instance regarding the maternal mortality the MICS-2 can only say that, with 95% probability, the MMR is not smaller than 1000 and not bigger than 2600 maternal deaths per 100,000 live births. More accurate data will only be available later on with: (i) the opportunity of a DHS (scheduled for 2003) and of specialized surveys (such as the HIV sero-positivity survey scheduled for 2002) and, gradually, (ii) the resuming of the health facility data collection and reporting system.

c) The health sector's capacity to manage health service delivery was considerably weakened, and the decentralization of decision-making halted in recent years. During the period 1993-1996, the MOHS prepared a comprehensive sector reform and service delivery program, which was outlined in documents such as the 1993 National Health Policy, the 1994 National Health Action Plan (NHAP) and the 1995 NHAP Core program. At the time, GOSL (using performance indicators and qualitative information) ranked health as the best performing public sector of the country; in more recent years, MOHS' performance has also been ranked very high. Recognizing these efforts, the World Bank agreed to develop a project to support the sector-wide program of the GOSL, the Integrated Health Sector Investment Project; credit 2827-SL. Unfortunately, the rebel conflict (which worsened in 1996 and sporadically thereafter) halted the reforms and re-focused MOHS's work on solving problems stemming from instability, loss of resources, an increasing number of displaced persons and refugees, and a marked deterioration of the health status of the population.

Although sector performance was greatly reduced by problems with financial resources, decrease of staff and looting of premises, the most affected parts of the system were, without doubt, the district health teams and the decentralization process.

IHSIP was restructured to provide the financing of activities in response to the new situation in the country, and remarkably permitted MOHS to continue functioning during all these years of war. To a large extent this was possible due to the dedication of the national staff and was facilitated by the assistance received from the IDA credit to the sector. Other organizations, such as UNICEF and WHO, have also succeeded in mobilizing extra budgetary resources and have provided valuable assistance. Over the past several years, sector capacity has gradually been re-established. In August 1999 the sector was able to resume the annual review and planning meeting with donors and NGOs, and launched the national immunization days. District health personnel, among which many have functioned mostly due to the support from international NGOs, attended these meetings. A decision was taken to increase the support to districts from the public budget and donors and, in addition, to also make available funds from the current IDA credit. In November 2000 the annual program review and planning meeting for the year 2001 was held with an even more active participation of NGOs, donors and district staff. Continuing this positive trend, at the beginning of the year 2001, the health districts meeting the criteria for satisfactory financial management and accounting practices received funding for their most urgent needs, conducting supervision or training from the current IDA project. During the same year the AfDB declared effective its credit and, in 2002, EU has intensified project preparation activities aiming at providing support to the health sector by early 2003.

Government Strategy: In the past years (1993-1995) the MOHS strategy was: (a) to rehabilitate health facilities using resources pledged by donors, and; (b) to further develop and reform the sector by means of a sector-wide program (i.e., the NHAP Core program) financed by the GOSL and by MOHS's traditional partners (such as WHO, UNICEF, UNFPA, Saudi Fund for Development, the Islamic Development Bank, the European Union, AfDB and IDA). During this period the Government's overall goals were to "improve social conditions and alleviate poverty along with sustained economic growth." In the health sector, the sector policy was translated into a five-year sector-wide program (NHAP) originally estimated at about US$270 million but downsized to US$138 million (NHAP Core program) after a more realistic analysis of the sector's financing capacity and absorption limitations. The main thrusts of the NHAP were to develop a sound health delivery system and to staff it adequately, promote environmental health and communicable disease control, foster community participation, decentralize services at district level, improve sector financing; privatize certain services and enhance international collaboration. To this sector-wide program, IDA contributed US$20 million through the Integrated Health Sector Investment Project, which was one of the first sector-wide operations in the Region. Starting in 1996, when the war and insecurity worsened, the MOHS has aimed to provide expanded health services to the increasingly large populations in safe areas (basically the Western Region) with reduced financial and material resource. Through 1999 the sector operated on the basis of Quarterly Emergency Plans, until the regular mechanism (set up in 1995) of reviewing sector performance and

planning for the following fiscal year was reinstated. This participatory planning process continued and was improved during the October 2000 and 2001 planning sessions and in particular in 2002.

GOSL, taking into account the progress in peace negotiations and the overall improvement of the security situation is currently updating the health sector policy. The new policy is two pronged and aims at: (i) re-establishing the provision of health services, and (ii) gradually strengthening the sector capacity to deliver services by decentralizing decision making, re-instating cost-recovery (in a manner that will preserve the affordability of drugs and services), and by improving sector management to obtain efficiency gains. The implementation of this new policy would be supported by the proposed IDA credit.

2. Objectives

The project's overall development objective is to help restore the most essential functions of the health delivery system. The project will also help achieve the more specific objectives of:

(a) Increasing access to affordable essential health services by improving primary and first referral health facilities in four districts of the country.
(b) Improving the performance of key technical programs responsible for coping with the country's major public health problems.
(c) Strengthening health sector management capacity to improve efficiency and further decentralize decision-making to the districts.
(d) Supporting development of the private health sector and involvement of the civil society in decision-making.

The first specific objective is limited in scope to the four districts which met specific selection criteria (such as importance to the demobilization, resettlement and peace processes; magnitude of the public health problems; clear need to rehabilitate the delivery of services, etc.). Within these four districts, the project focuses on the rehabilitation of priority health facilities, and on support for the delivery of affordable and good quality care.

Through its second specific objective, the project will contribute to reducing the burden of some of the most important infectious diseases country-wide (i.e., by supporting Malaria and TB control activities, and the Sanitation program).

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

The fourth specific objective will improve the quality of services by (i) promoting development and regulation of the private sector, strengthening the quality of care and enhancing the contribution of the private sector to the achievement of public health objectives, (ii) providing incentives to the health providers to establish practices in rural areas and smaller cities, (iii) contracting out clinical and non-clinical services with the private sector, and by (iv) involving the civil society in decision making

in the health administration and in health facilities.

While the project must initially focus on the restoration of health delivery, it will provide increasing support to the reform process in the health sector (including to cost-recovery and to the set up of mechanisms to protect the access to services of the poorest population).

3. Rationale for Bank's Involvement

The Bank's contribution to the health sector in Sierra Leone is much praised by the Borrower and its development partners. Besides the Bank support during the war, the Bank has uniquely contributed to sector policy formulation, sector planning, and capacity-building at both MOHS and decentralized levels. Very importantly, the Transitional Support Strategy for Sierra Leone defines clearly the Bank support to this country and also makes projections on the economic growth in the years to come. The proposed project would allow this assistance to continue and to grow. It would also contribute to poverty reduction in Sierra Leone through HSRDP focus on the poor and under-served populations. IDA funding would complement other donors' funding to the programs dealing with major public health problems and of a greater benefit to the poor population such as PHC, malaria, TB, and sanitation. The HSRDP would also help achieve some of the reform and development objectives of the IHSIP project (as mentioned, IHSIP was restructured to better respond to the crisis situation in the sector and could not achieve some of its initial objectives as for instance to develop health services outside the Western Region and to substantially contribute to the reform process).

4. Description

Component 1: Restoring Essential Health Services.

This component will: (a) provide assistance to four priority districts to deliver adequate health services and (b) support three priority technical programs to improve their performance and control infectious diseases of high public health importance in Sierra Leone (i.e., Malaria, TB and Sanitation).

1.1 Restoring health service delivery in four priority districts (Bombali, Koinadugu, Kono, Moyamba). The project will finance equipment, drugs, vaccines, furniture, training and supervision needed for the adequate functioning of 50 health posts built with support from the IDA funded Community Reintegration and Rehabilitation Project and from other social fund projects. The project will also finance civil works, equipment, rehabilitation and upgrading of water distribution and medical waste disposal systems, essential staff quarters, training, communication means and ambulances for 12 health centers and four first referral hospitals. Finally, it will provide support to ensure the delivery of adequate health care and to solve health provider shortages and other human resources issues in the participating districts. Particular attention will be paid to health facility waste management and to related IEC activities for health providers. As all these activities will be carried out at existing and operating health facilities (and in addition, for the hospitals within the hospital compound) this sub-component will therefore not necessitate land acquisition and will not cause any resettlement of the population or removal of squatters.

It is worth mentioning that while maintenance and drug availability

(procurement, stock management and distribution) will be strengthened at the central level with the support of other MOHS's partners (AfDB and EU), IDA will contribute in a concrete manner in the four participating districts, by funding drugs, condoms and other contraceptives, consumables, vaccines, micronutrients and food supplements, spare parts and other non-salary recurrent expenditures. IDA will also rehabilitate and equip district drug stores and train the respective personnel. Likewise, IDA support at central level (see the second sub-component) will only target some key technical and support programs (and not all of them, as several have already obtained assistance from other donors). However, in the four participating districts, IDA will support, to the extent needed, the delivery of all essential preventive and curative care, thus being able to contribute to the improvement and expansion of all major public health programs. For instance, because the Reproductive Health Program, including Safe Motherhood and Family Planning, Nutrition and Expanded Program of Immunization are already being supported by WHO, UNICEF, UNFPA and several bilaterals, these programs were not included among the technical programs to receive IDA assistance at central level. However, if and when needed, IDA will support such activities in the four participating districts.

1.2 Support to priority technical programs.
The project will provide support to improve the performance of the following programs important for the reduction of three priority public health problems in Sierra Leone:
(i) Malaria control activities consistent with the RBM strategy and focusing on the strengthening of case management capacity in public and nongovernmental facilities, the promotion and distribution of insecticide-treated bed nets (to be distributed and re-treated with local NGO support), and strengthening the capacity for monitoring and supervision;
(ii) TB control activities will include establishing/strengthening diagnostic laboratory capacity, training of health workers in case detection and appropriate treatment, and logistic support for the implementation of the DOTS strategy;
(iii) Sanitation and environmental impact mitigation measures in the four districts supported by the project. Regarding sanitation, a program of importance for all infectious disease control programs and for prevention in general, the project will support activities to be contracted out with private providers and advocacy for involving the municipalities in the four districts and communes in waste management (thus redefining the task of the MOHS from a provider of services to contract management and environmental monitoring; the ultimate objective of this program will be to transfer sanitation responsibilities to municipalities and communes). Regarding environmental impact mitigation the project will finance (a) medical waste management measures in the 12 health centers and, in particular, in the four district hospitals to be rehabilitated (incinerators, lined pits, latrines, including support for their maintenance and functioning, training of relevant staff and of health providers), (b) TA for an adequate identification and development of dump sites (which will also include liquid waste disposal) of the four district capital cities, (c) transportation means for solid waste and (d) supervision and monitoring by environmental inspectors of the district health teams of the four districts. The SHARP project will also support environmental impact mitigation in the four districts by financing, among

others, training of health providers in medical waste issues and management.

All other priority technical programs of the MOHS will also be supported, to the extent needed, through HSRDP assistance to the four priority districts (mentioned above under the sub-component 1.1).

Component 2: Strengthening Public and Private Sector Capacity.
Under this component the HSRDP will support: (a) in all the districts of the country, the decentralization process by strengthening the District Health Management Teams (DHMT), improving the decision making process, and enhancing capacity for appropriate planning, management, financial management and supervision; (b) essential sector management functions carried out by five key MOHS units (i.e., Planning, Monitoring and Evaluation, Financial Management, Procurement, Donor & NGO Coordination and Human Resources Development) to improve efficiency and improve the administrative performance at the central level and at the periphery; and (c) initiatives to promote private sector and civil society participation in the health sector and to develop mechanisms to increase the efficiency, ensure the equity, and improve the quality of services provided.

2.1 Promote decentralization and improve the performance of District Health Management Teams.
To support the reforms (currently underway) to decentralize budget management, the Project would finance training of district level financial officers and provide discretionary funds to the qualifying districts (i.e., those meeting the criteria for adequate financial management). HSRDP funding will be channeled following an already existing mechanism for district "discretionary" funding established by the IHSIP (i.e., the districts meeting criteria of sound financial management are eligible, the funds ought to be used for unplanned activities for which the public budget is not sufficient such as supervision, emergency operations in case of infectious disease out-breaks, etc.). Although, only up to a total of US$0.4 million will be spent for the entire duration of the project for this type of funding, this sub-component is expected to greatly assist DHMT to make their own decisions and manage in a hands-on manner problems unforeseen at the planning stage.

2.2 Strengthen the key MOHS support services, i.e., Human resources development (HRD), Planning, monitoring and statistics, Financial management, Procurement and Donor/NGO coordination. The Project would provide ongoing support for the improvement of staff skill and performance, and for the implementation of activities of selected key support services of the MOHS. These key support services have been selected on the basis of their importance to improving sector efficiency, insufficient funding from other sources, and the Borrower's intention to implement the project using MOHS's capacity (and not with a PCU).

Planning, monitoring and statistics. The Project would provide operational support to meet the department's needs in equipment, transport, communications, training and technical assistance, and specific support to: (a) revise and disseminate the national health policy; (b) reinforce the medium-term planning and operational planning exercises as well as the annual sector review; and (c) strengthen both routine health information management and periodic surveys and research. With support

from a PHRD grant, MOHS has revised the 1993 National Health Policy and adapted it to the current health status of the population and the situation in the sector. HSRDP will finance the dissemination and public discussion of the final updated policy. The planning process would be strengthened by: (i) improving the Planning Department's ability to collect and analyze information on health sector expenditures; (ii) revising the planning guidelines to institute a Three-year Rolling Plan and improve the Annual Operational Planning; and (iii) improving the planning capabilities of the District Health Management Teams. The project would continue to support the organization of the annual sector review. The project would also provide financial support for (i) the improvement of health information systems at central and district-levels; (ii) vital registration, and; (c) the execution of selected surveys and operational research to be determined annually.

Donor/NGO Coordination. Within the framework of MOHS's intention to develop a new NGO policy with procedures and guidelines for effectively coordinating and monitoring the activities of NGOs, the project would finance TA, as well as equipment and modest operating costs. The project would support current work to involve and coordinate donors, technical agencies, financing institutions and international and national NGOs and to expand their participation in the decision-making, among others, capitalizing on the opportunity of annual sector review and planning exercises. In addition, the project would finance periodic meetings between MOHS and its partners as well as the collection and publication of the annual inventory of donor and NGO interventions in the health sector.

Human Resources Development. The project would support a series of actions to strengthen human resource management and reduce the shortage of health service providers. These actions will be closely coordinated with and complementary to ongoing efforts by WHO and AfDB and particularly by the proposed EU-financed Health Sector Support Project. Specifically, HSRDP would strengthen the overall capacity of the Human Resource Department to implement the Government's Public Service Reform Program, focusing specifically on providing technical and financial support for: (i) personnel management through improved personnel record keeping and (ii) manpower planning through formulation (and subsequent updating) and implementation of a comprehensive manpower development plan. HRSDP will also provide support for strengthening training institutions, introducing specialized or in-service training courses, or other activities as appropriate.

Finance. The project would provide TA and overall operational support for the Finance Department to improve its performance, carry out its tasks related to the FM of the IDA credit and effect improvements in financial management and control. In addition, the Department will receive assistance to computerize financial management operations; complete installation of a system acceptable to the Bank, and train staff.

Procurement. To enhance the capabilities of the Procurement Unit of MOHS, the project would: (a) strengthen existing systems and procedures for procurement planning and implementation; and (b) extend these methods for use in carrying out procurement with GOSL funds. To ensure the continued development of the Procurement Unit of MOHS, the Project would finance TA (procurement and architect) and would support additional short-term

training and improved working conditions for existing staff (i.e., furniture, equipment and operating costs).

2.3 Promote development of the private sector and civil society participation in the health sector.
The project would support initiatives in the following areas of particular importance to the MOHS:

Public sector/Private sector consultation and development of regulation to foster quality and participation. The Project would finance consultations with the private Medical, Dental and Pharmaceutical Associations and meetings with the Traditional Medicine Association to discuss ways for strengthening collaboration and registration and accreditation practices (and other measures to improve quality). Further to these consultations the project will support the issuance of regulation to promote quality of services, control tariffs and encourage the development of private health services and the involvement of private providers in the solving of public health issues.

Contracting out. Contracting out of clinical and non-clinical services with the private sector is already envisaged by HSRDP in areas such as impregnated bed-nets, IEC services, and solid-waste collection by communities. Substantial financial support to contract out services has also been foreseen under the HSRDP Component 1, but additional support could be made available in case of insufficient funding. The Project would also finance a study on contracting out (or privatizing) other selected public services (clinical or non-clinical), including drug procurement and distribution, laboratory services, and laundry.

Incentives for private providers of health services. Given the importance of attracting the return of religious and other NGOs to develop and discharge hospital services and equitable cost recovery arrangements (i.e., protecting the access to services of the poor individuals) in the under-served geographical areas, the Project would finance specific incentives, which might include the provision of a drug stock to cover the needs of the respective facility for one year.

Support to the District Health Development Committees. To encourage the establishment and functioning of committees (at district and health facility levels) for involving the population, political and religious leaders and, more generally, the civil society in the decision making on health matters, the Project would provide financial resources for their operations. While the emphasis would be on the four IDA-financed districts, the Project would provide support to the PHC program of the MOHS to finance similar activities in the remaining districts. These efforts to increase the involvement of the users of services and the civil society in the decisions made in the health sector will be synchronized with MOHS work to regulate cost-recovery and will include mechanisms to protect vulnerable populations. HSRDP would finance: (a) a feasibility study (to be carried out with consultant assistance and with the participation of MOHS and district staff) of approaches for establishing local financing mechanisms; (b) testing and consensus-building concerning these possible approaches (either by MOHS or through an NGO partner); and (c) preparation of the guidelines to establish such a system. An equity fund to pay for the delivery of services for the benefit of the poor

population in one of the facilities rehabilitated with HSRDP support will be tested. The project would also consider, at the time of the mid-term review, establishing two prepayment arrangements on an experimental basis to finance health care for the population of one small urban and one rural community and test their feasibility (in economic terms and from an equity perspective).

5. Financing
Total ( US$m)
BORROWER $1.00
IBRD
IDA $12.00
IDA GRANT FOR POST-CONFLICT $8.00
Total Project Cost $21.00

6. Implementation
The capacity created in the MOHS by the IHSIP project (in terms of planning, financial management and procurement) proved to be a good investment. Using this capacity the MOHS succeeded in implementing the previous credit satisfactorily in spite of the difficult conditions that prevailed in the country from 1995 to 2001. It is, therefore, proposed to continue strengthening MOHS capacity and use it to implement the proposed project without setting up a separate project unit. See also section E 4.1 and 4.2 below on Institutional issues and the PIP.

7. Sustainability
The sustainability of the HSRDP is linked to the success of the Government's implementation of its recovery and reform program, within a sound macro-economic framework. The PER listed a number of issues which must be addressed to ensure sustainability of the health care system and which are of relevance for the sustainability of the project. Services cannot be delivered without adequate numbers of trained and motivated personnel, either in the public and private, and this implies a larger capacity to train and adequate current expenditures to pay personnel. Proposed budgetary allocations show imbalances between present capital expenditure (mostly external sources) and future operating expenditures from domestic sources. In the medium term there will be need to overcome current dependence on external funds through increased domestic revenues.

At this time, there are still districts in which Government control has only recently been restored and in which electricity, telephone and other communication, transport and banking facilities do not operate fully. While recent macroeconomic projections predict growth of more than 5% for the next few years, the projected increases in revenue seem rather modest. In other words, until this situation is changed, in Sierra Leone more than in other developing countries, the funding of the health sector will be highly dependent on external sources. Therefore, within the limits of prudent fiscal management, as the macroeconomic situation improves, there is urgent need to (a) increase the share of the budget allocation to the health sector to reasonable levels and also (b) seek domestic sources of funds that will ensure the future sustainability of the health delivery system with a lower dependence on external sources. These issues ought to be one of the priorities in the Bank's dialogue with the Government (including the PRSP dialogue).

Nonetheless, reforms of the public health system supported by the project will improve performance and make the public sector more credible to consumers of services. They will also promote efficiency in the provision of more effective and relevant services. Improvements in the country's economic situation should also enhance the capacity to pay for services of greater relevance and quality. These conditions should increase the potential for revenue collections from fees for services and charge for drugs supplied provided that appropriate financial management at local level is improved.

While the above is likely to happen in the midterm, immediate prospects are less clear as the population is generally poor and the underserved groups, in particular in the districts supported by HSRDP, are numerous. For this reason, the project has included measures not only to improve sector financing and efficiency but also to reinstate cost recovery with appropriate safeguards to assure affordability of services for the underserved groups.

8. Lessons learned from past operations in the country/sector
The current project (IHSIP) as well as the first IDA credit to the health sector in Sierra Leone (Health Services Development Project) helped identify a number of positive features such as: the sector's ability to develop a transparent program and to work with all parties involved in a convivial manner; the increasingly satisfactory level of performance in planning, financial management and procurement; and the sector's willingness to collaborate with NGOs. At the same time, the sector was less successful in implementing technical programs and in decentralizing decision making; this was due not only to difficulties linked to the war and instability but also to conflicting donor policies (e.g., reproductive health and mother/child health), insufficient capacity to lead these programs, and delays in public sector reforms (such as decentralization, computerization of financial management in the public sector, simplification of procurement operations which involve the Central Tender Board in the approval process of minor transactions, etc.) which have hindered developments in the health sector. Based on these lessons, HSRDP is proposing to capitalize on capacity already developed in the MOHS to implement the project without creating a Project Implementation Unit. Moreover, to avoid the above mentioned drawbacks, project preparation has been carried out with the full participation of other donors, and the Borrower has agreed to evaluate bids using the MOHS tender board (which will include representation from the Central Tender Board).

The analysis of the experience in implementing technical programs led to other project features such as an emphasis on NGOs for social marketing of impregnated bed-nets and condoms, more attention to contracting out activities (clinical and non-clinical) with the private for-profit and not-for-profit sector, increased preoccupation with demand raising activities (in particular for bed-nets).

The most successful feature of the IHSIP project (i.e., its capacity to plan taking into account changes in health status and in the overall situation in the country by using a participatory annual review and planning process) was also included in the proposed project's design. While the HSRDP credit was fully allocated during project preparation, implementation arrangements include the possibility of questioning the

pertinence of these allocations annually and of making adjustments during the annual participatory program review and planning process.

9. Environment Aspects (including any public consultation)

Issues : There are no significant environmental issues.

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Note: This is information on an evolving project. Certain components may not be necessarily included in the final project.

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