



Republic of Sierra Leone
National Monitoring and Evaluation Agency
Office of the President



**Sierra Leone Quality Essential Health Services and Systems Support
Project (QEHSSSP)-P172102**

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A National Monitoring and Evaluation Agency Report

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List of Acronyms

ANC	Antenatal Care
CERC	Contingent Emergency Response Component
CHC	Community Health Centre
CHO	Community Health Officer
CHW	Community Health Worker
DFN	Directorate of Food and Nutrition
DHMT	District Health Management Team
DMO	District Medical Officer
FMC	Facility Management Committee
GBV	Gender-Based Violence
GoSL	Government of Sierra Leone
HUB	Central facility in the "Hub and Spokes" service delivery model Central health facility linked to smaller peripheral units)
HRH	Human Resources for Health
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association

IHPAU	Integrated Health Projects Administration Unit
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDA	Ministry, Department, or Agency
MTR	Mid Term Review
MMR	Maternal Mortality Rate
NaMEA	National Monitoring and Evaluation Agency
PFM:	Public Financial Management
PIH	Partners in Health
PM&E	Project Management and Evaluation (contextual)
PHC:	Primary Health Care
QEHSSSP:	Quality Essential Health Services and Systems Support Project
RMNCAHN	Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition
RMNCHN	Reproductive, Maternal, Newborn, Child Health, and Nutrition
UBC:	United Brethren in Christ Hospital)
WHO:	World Health Organization (not explicitly stated but commonly referenced)

Review of the Quality Essential Health Services and System Support Project (QEHSSSP)

Executive Summary

This report presents findings from review of the Quality Essential Health Services and System Support Project (QEHSSSP)¹ which is funded by the World Bank with an allocation of USD 60 million for a five-year period (2022 to 2027) conducted in November 2025. Building on prior health initiatives, the QEHSSSP is designed to improve health outcomes through a decentralized, **hub-and-spoke service delivery model** at the district level, integrating digital innovations and private sector engagement. The project focuses on five target districts: Bonthe, Falaba, Kailahun, Tonkolili, and Western Area Rural.

The QEHSSSP aims to strengthen maternal, newborn, child, adolescent, and nutrition services across the target districts, enhance systems and community outreach. Delivery of the project uses a hub-and-spokes model for service delivery through a network. At its core is an anchor health facility (hub) that offers a wide range of services. Lower-level facilities (spokes) provide more limited services and refer patients who require more intensive care back to the hub for treatment.

The following significant progress were made : **System Strengthening:** 2,333 health care workers were trained in key maternal and child health topics, and data management² and referral pathways have improved with the provision of free ambulance services, contributing to increased community trust and patient flow.

- **Operational Gains:** At least 75% of hubs now offer 24/7 services, demonstrating improved facility utilization though Particular attention should be given to Falaba

¹ The review was conducted by the National Monitoring and Evaluation Agency (NaMEA) with funding from the United Nations Development Programme (UNDP).

² Annex 8: PIH Database for QEHSSSP project

and Masingbi for improvement in ambulance services, therapeutic feeding, and management of the facilities.

Critical Challenges and Gaps:

1. **Resource Constraints:** At the time of our assessment, **53%** of facilities reported shortages of medical supplies, **47%** inadequate infrastructure, and **40%** limited human resources as impediments to the successful delivery of the project.
2. **School Health: Eight** out of ten enlisted schools indicated that there are no functional school health clinics, which undermines the delivery of a key activity of the project.
3. **Gender-Based Violence (GBV):** The GBV support centers in Kailahun and Bonthe districts, associated with the QEHSSSP project, at the time of the assessment were significantly deficient in GBV kits. Respondents indicated that the procurement of the GBV kits has been in the pipeline for over two years.
4. **Operational Inefficiencies:** Procurement delays at the start of the project were common, hindering timely operations.

Coordination Issues: Ensure adherence to the roles and responsibilities defined in the Project Implementation Manual (PIM) for effective coordination among the stakeholders.

Despite project efforts, health outcomes are mixed and require urgent solutions/remedies,

✓ **Maternal Health:** while the inflow of patients and deliveries in the hubs increased between the 2021 and Quarter 3, 2025, maternal mortality across project-supported hubs decreased by 32%. Cumulatively, 139 maternal deaths were recorded by all hubs for the period 2021–2025. Even though facility-level maternal death rate rose by 0.6 percentage points in 2024, this increase was significantly reversed to a 0.3 percentage-point in 2025³.

✓ **Patients/Maternal Care:** The ANC 4+ visits across the 14 hubs improved from - 5.9% in 2021 before QEHSSSP to 14.6% in 2025. Of the 14 hubs assessed, there was a decrease of 4.4% in ANC 4+ visits in the project implementation hubs between 2023 and 2024. However, in 2025, ANC 4+ increased to 31%. Although there is an observed fluctuation in the antenatal care program, there is an overall increase in this service. For institutional delivery rate, there was a 6% decrease in

³ MMR = Facility death/institutional delivery.

2024 and a 24% increase in 2025. However, UBC, Hinistas, and Waterloo have more deliveries above the expected facility delivery. (771, 263, and 1876 for Hinistas, UBC, and Waterloo, respectively)⁴. (See Figure 2).

- ✓ **Child Health:** The SAM cure rate among children identified as enrolled in the OTP increased by 1% in 2024 (from 89% in 2023 to 90% in 2025) but declined by 4% in 2025 (90% in 2024 to 86% in 2025). The number of children screened and identified with SAM in the hubs increased from 2,107 in 2023 to 2,669 in 2024 and 3,447 in 2025. This implies it is rational to consider the prevention of severely acute malnutrition while addressing the clinical outcomes in outpatient therapeutic program.
- ✓ Under-five mortality rose by 18% in 2022 from 2021 and by 86% in 2023 from 2022. Immunization rates fluctuate, and nutrition services for severely malnourished children are erratic.

To optimize impact, the following actions are recommended:

- **Accelerate Infrastructure & Supplies:** Fast-track facility rehabilitation and resolve supply chain issues.
- **Address Service Gaps:** Establish functional school clinics and equip one-stop GBV centers with GBV kits.
- **Clarify Governance:** Define and implement clear roles and accountability for IHPAU, MoHS, and partners to improve coordination.
- **Enhance Data Quality:** Improve reporting consistency to better track progress and outcomes.

Conclusion:

The QEHS SSP is on track in achieving its objectives of improving maternal, newborn, child, adolescent, and nutrition services while laying the foundation for improving RMNCAHN services and a stronger health system in Sierra Leone. While progress has been made in service delivery and community health engagement, challenges in supply chain management, resource use in implementing some activities, staffing, and governance are preventing the full achievement of intended health outcomes. Sustained and focused action on these fronts is critical to advancing maternal, child, and adolescent health care.

⁴ 2024 expected population for pregnant women for hubs)

1. Introduction and Background

Sierra Leone's post-Ebola economic recovery was significantly reversed by the COVID-19 pandemic. The crisis strained public finances, increased debt, and exacerbated longstanding health and human development challenges. The health sector continued to face significant challenges, including inconsistent service quality, inadequate health system capacity, fragile information systems, and inadequate management of medical waste. Significant gaps persist in specialized areas such as school health programs and services for survivors of gender-based violence (GBV).

In response to the above, the government, with support from the World Bank, initiated the Quality Essential Health Services and Systems Support Project (QEHSSSP). Aligned with the Medium-Term National Development Plan (MTNDP), the QEHSSSP aims to strengthen health governance, human resources, and data systems; enhance primary and secondary healthcare; foster public-private partnerships; modernize digital infrastructure; and revitalize school health services.

Building on prior health initiatives, the QEHSSSP is designed to improve health outcomes through a decentralized, **hub-and-spoke service delivery model** at the district level, integrating digital innovations and private sector engagement. The project focuses on five target districts: Bonthe, Falaba, Kailahun, Tonkolili, and Western Rural.

The project is structured into four core components:

1. **Improving Quality, Efficiency, and Effectiveness of RMNCAHN Services** (US\$31.5 million): Enhances delivery of Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition services in the five target districts.
2. **Strengthening National Level Systems** (US\$20.5 million):
 - *Subcomponent 2.1:* Focuses on leadership, human resource development, public financial management, pharmaceutical supply chains, and private sector engagement.

- *Subcomponent 2.2:* Addresses epidemic preparedness, non-communicable disease surveillance, and medical waste management.
- 3. **Project Management, Monitoring & Evaluation** (US\$8.0 million): Provides oversight, coordination through the MoH, and capacity building for data collection and knowledge management.
- 4. **Contingent Emergency Response Component (CERC):** Allows for the rapid reallocation of resources to respond to national emergencies or disasters.

Specific monitoring Objectives

- Assess the degree of implementation and functionality of the Hub and Spokes model.
- Assess clarity and functionality of referral pathways and feedback mechanisms between facilities.
- Assess the activity levels of community-based disease prevention, nutrition, and health promotion initiatives.
- Determine the establishment and functionality of school health clinics
- Review adherence to financial controls and procurement guidelines to ensure transparency.
- Assess the supply chain efficiency for therapeutic commodities.

2. Methodology

2.1 Study Design

A mixed-methods approach was employed to comprehensively review performance and progress in the QEHSSSP's implementation. This integrated quantitative and qualitative techniques provided a holistic and comprehensive assessment of the performance, achievements, and implementation progress of the QEHSSP. Purposive sampling was used to select community health and census of all District Health Management Teams (DHMTs) within the beneficiary districts were mapped out and included for expert interviews.

Stakeholder Engagement

The study engaged a diverse range of stakeholders across five project districts:

- ✚ Primary service right holders: lactating mothers, pregnant women
- ✚ Health service providers: Facility in-charges, nurses, Community Health Workers (CHWs)
- ✚ Health system management: District Health Management Teams (DHMTs), District Medical Officers (DMOs)

- ✚ Community representatives: Lactating mothers, pregnant women, Facility Management Committee members
- ✚ Project partners: Representatives from PIH, IHPAU, DPPI, and the Directorate of Food and Nutrition

2.2 Sampling

Random purposive sampling was employed to ensure geographic and demographic representation.

Two Community Health Centers (CHCs) or hub catchment areas were randomly selected from three available per district. This ensured representativeness of district-level health service delivery. Within each selected hub, key health service providers and users, as well as allied community structures, were purposefully identified for data collection.

This strategy allowed the monitoring team to focus on key individuals or groups who have the best knowledge, experience, or characteristics that can provide rich, relevant, and insightful data about the project's progress and impact.

- Two facility questionnaires were administered to 14 facility in-charges, with 100% of QEHSPP project locations covered.
- All DHMTs in beneficiary districts are included for expert interviews. In this respect, five (5) DMOs were engaged as sources.
- Key Informants (KI) selected from FMC Chairman, FMC Secretary, CHW, health personnel at the facility, active service users (lactating mothers, pregnant women), and each stakeholder category. As such, 60 key informants were interviewed across 10 project locations.

2.3 Data collection

Data collection incorporated both primary and secondary sources, involving the collection of both quantitative and qualitative data. Within each selected hub, key health service providers and users, as well as allied community structures, were identified for data collection.

2.3.1 Secondary data

- Desk review of project documents (project appraisal document (PAD), project information document (PID), project status reports) and report of the Midterm Review (MTR)
- Extraction of health service data from DHIS2
- Record Verification: Cross-checking of stock cards, ration cards, and administration records

2.3.2 Primary data

Quantitative data

Key informant interviews

Structured questionnaires with a Likert scale were administered to key informants to elicit measurable perceptions about project performance. The 60 KIs, purposively selected, include:

- ❖ Facility Management Committee (FMC) Chairpersons and Secretaries,
- ❖ lactating mothers, pregnant women, health facility in-charges,
- ❖ CHWs, DHMT members, hospital nurses, and
- ❖ representatives from partner institutions such as PIH, IHPAU, DPPI, and the Directorate of Food and Nutrition (DFN).
- ❖ Five District Medical Officers (DMOs) were engaged as expert sources

Qualitative data

Focus Group Discussions

Using semi-structured interview guides, Ten (10) Focus Group Discussions were held with community members (lactating mothers, pregnant women, CHWs)

Direct Observations:

The assessment carried specific observations of facility infrastructure, hygiene, and protocol adherence

Triangulation: Verification follow-ups with five beneficiaries of therapeutic feeding was used to triangulate data on ration cards, stock cards, and administration records to confirm receipt and use of nutrition commodities. Field teams conducted formal entrance and exit meetings with stakeholders at CHCs/Hubs and DHMT offices to clarify objectives, foster cooperation, and share preliminary findings during data collection.

2.4 Data Quality and management

For efficient data capture, quality assurance, management, and storage

- Data was collected digitally through KoboToolbox.
- Triangulation of data from multiple sources (KIIs, FGDs, observations, records)
- Formal entrance and exit meetings with stakeholders at CHCs and DHMT offices

Quality Assurance

- Structured training sessions for data collectors to ensure tool consistency
- Daily debriefs and supervision by senior monitoring staff
- Triangulation of ration cards, stock cards, and administration records to confirm receipt and use of nutrition commodities including verification follow-ups with five beneficiaries of therapeutic feeding
- Ethical standards, including anonymity and confidentiality maintained throughout data collection

Limitation of the monitoring

- Overall, time constraints restricted the depth, frequency, and responsiveness of monitoring activities.
- There are potential gaps in quality assurance and risk mitigation of the health facility construction and rehabilitation under QEHSSSP.
- In due time, the financial aspect of the project (disbursement against result is not included here but will be followed up in due course.

2.5 Analysis of Key Findings

This section provides a detailed analysis of the findings from the review of the project. It examines each component of the project as linked to the objectives that the project is planned to achieve, which are to enhance Reproductive, Maternal, Newborn, Child, Adolescent Health, and Nutrition (RMNCAHN) services and strengthen the national health system.

Component One: Improving Quality of RMNCAHN Services

This component aims to improve health outcomes by enhancing service quality and increasing utilization.

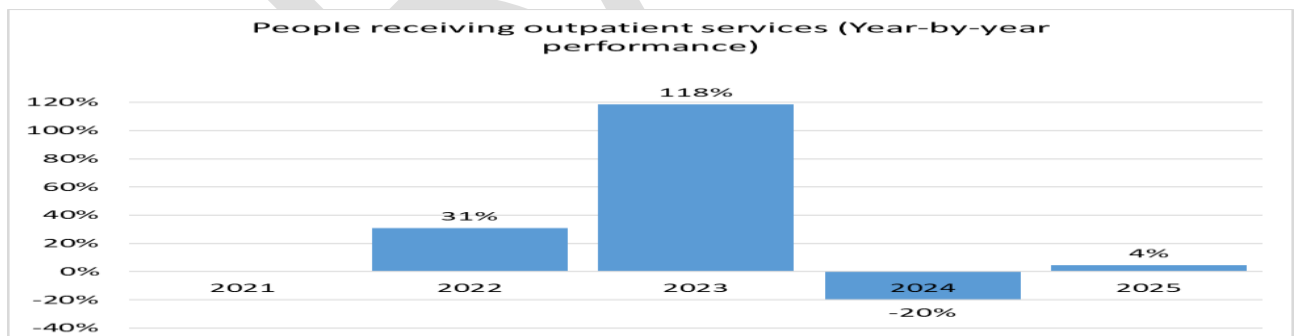
Outpatient Service Coverage: 2021-2025

Outpatient visits across the hubs increased by 94% over the review period, rising from 124,148 visits in the pre-QEHSSSP baseline to 241,285 visits during the most recent reporting period. (Footnote: DHIS2)

Year-on-year performance:

- ✓ 2021-2022: Visits increased by 31% , indicating a strong recovery and expansion in service utilization following the baseline period.
- ✓ 2022-2023: Growth continued but moderated, with visits rising by 87% compared with 2022.
- ✓ 2023-2024: The trajectory reversed; outpatient visits declined by -20% relative to 2023.
- ✓ 2024-2025: Decline persisted, with a further 4% reduction compared with 2024⁵.
(See figure 1 below)

Figure 1: People receiving outpatient services (2021-2025) across the 14 hubs



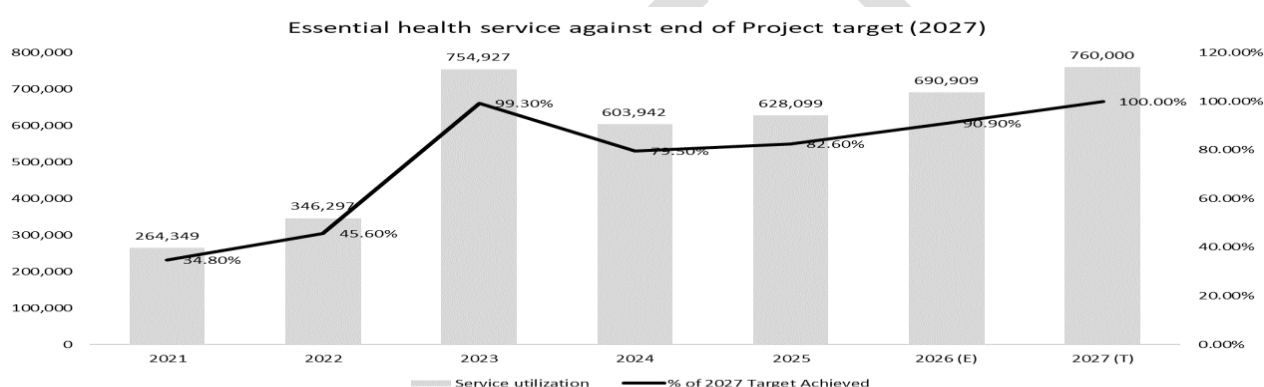
Source: Project target for Out Patients (OP) Visits = 760,000 by 2027

People accessing Essential health services across the 14 hubs

⁵ Sum {Pentavalent 3rd dose (In facility + Outreach), Child 12-59 months given Vitamin A supplementation, Antenatal client given iron folate/MMS, Delivery by Doctor/Midwife/ SACHO/SECHN, Delivery by CHO/CHA/SECHN/MCH Aides}

Based on the project target of 760,000 outpatient visits by 2027 and assuming a consistent 10% annual growth rate for 2026 and 2027 from the 2025 achievement, the estimated baseline for 2021 is approximately 264,349 outpatient visits (34.8% of the 2027 target). Performance in 2023 reached 754,927 visits (99.3% of the 2027 target), reflecting exceptionally high service utilization that year. However, utilization declined in 2024, reducing achievement to 79.5% of the 2027 target. The current projection for 2025–2027 assumes a steady annual increase of roughly 10%, which would bring total outpatient visits back in line with and achieve the 2027 target of 760,000 visits⁶.

Figure 2: Utilization of Essential Health service against end of project target



Source: Outpatient Service Utilization- Secondary Data from DHIS2

Implications for monitoring, implementation, and risk management

Programmatic interpretation: The near-target performance in 2023 demonstrates that the 2027 target is achievable under favourable conditions; the 2024 decline, however, shows that service utilization is sensitive to contextual or programmatic disruptions. Project activities should therefore prioritize interventions that sustain demand and service delivery continuity.

- ❖ *Target realism and adaptive planning: Given the volatility between 2023 and 2024, maintain flexibility in annual targets and incorporate a trigger-based contingency plan (for example, corrective actions if annual attainment falls >10% below projections).*

⁶ Project Result Framework

- ❖ *Monitoring priorities: Strengthen routine data quality assurance (DQI), timeliness, and disaggregation (by facility, district, age group, and service type) to quickly detect and respond to downward trends. Triangulate facility-reported outpatient visits with community outreach, stock management, and human resources indicators to identify supply- or demand-side bottlenecks.*
- ❖ *Risk identification and mitigation: Investigate causes of the 2024 decline (e.g., supply shortages, staffing gaps, financing disruptions, community access barriers, or external shocks). Design mitigation measures such as mobile outreach, temporary staff surge capacity, transport subsidies, or targeted communication campaigns to restore utilization.*
- ❖ *Resource allocation and prioritization: If the 10% annual growth assumption is retained, ensure budgets and human resource plans reflect the required scale-up for 2026–2027 (supplies, staffing, supervisory visits, and data systems). Conversely, if the 2024 downturn signals longer-term constraints, revise resource plans to target high-impact, cost-effective interventions that maximize visits per unit cost.*
- ❖ *Evaluation and learning: Commission a rapid operational review to explain the 2024 decrease and to assess whether the 10% annual growth assumption remains valid. Use findings to update the Result Framework, annual workplans, and the project’s theory of change.*
- ❖ *Reporting and stakeholder engagement: Present these findings and the recommended adaptive measures to donors and government counterparts, emphasizing the evidence that the target is attainable but contingent on mitigating identified risks and strengthening routine monitoring.*

1.1. Antenatal Care (ANC) Attendance

The monitoring team conducted a verification of the PIU-reported operational indicator “pregnant women attending ANC4+ visits by skilled health personnel” (the PIU combined fourth and eighth visits and reported results as a percentage). District-level verification for the four-year period shows the following absolute and percentage values:

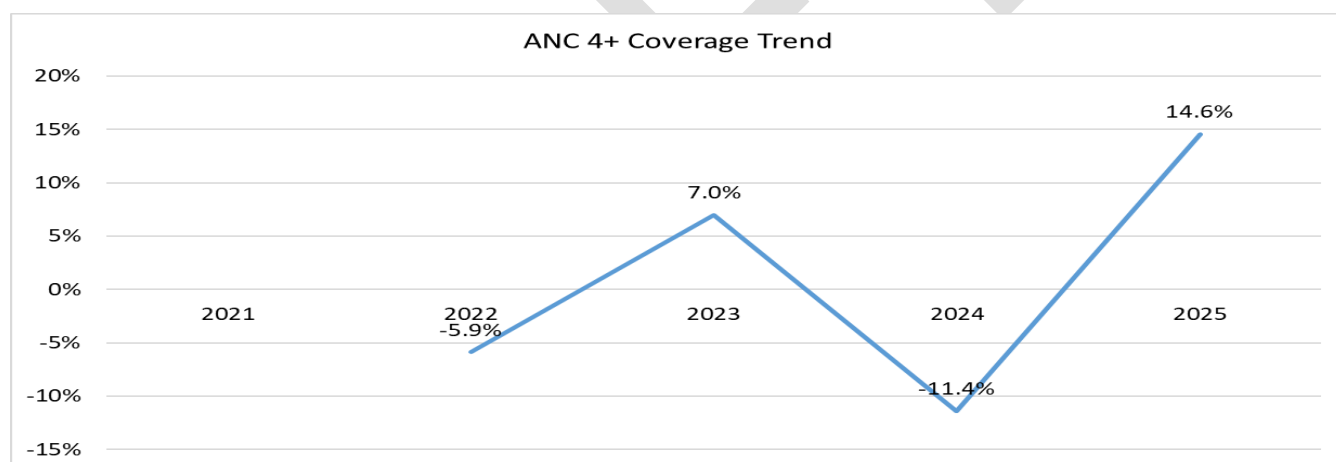
- ✓ 2022- 59,772 (79%);

- ✓ 2023- 84,728 (89%);
- ✓ 2024- 80,231 (71%); and
- ✓ 2025 (Q3)- 67,189 (82%).

District level performance fluctuated year to year- with a peak in 2023, a decline in 2024, and partial recovery by Q3 of 2025. All districts consistently met or exceeded their annual targets, including the 75% coverage target set for 2025.

These results suggest overall sustained improvement in ANC4+ service utilization across the five target districts, while the 2024 dip highlights the need for further investigation into district-level factors (for example, service disruptions, data-reporting changes, or demand-side barriers) that may have caused the temporary decline⁷.

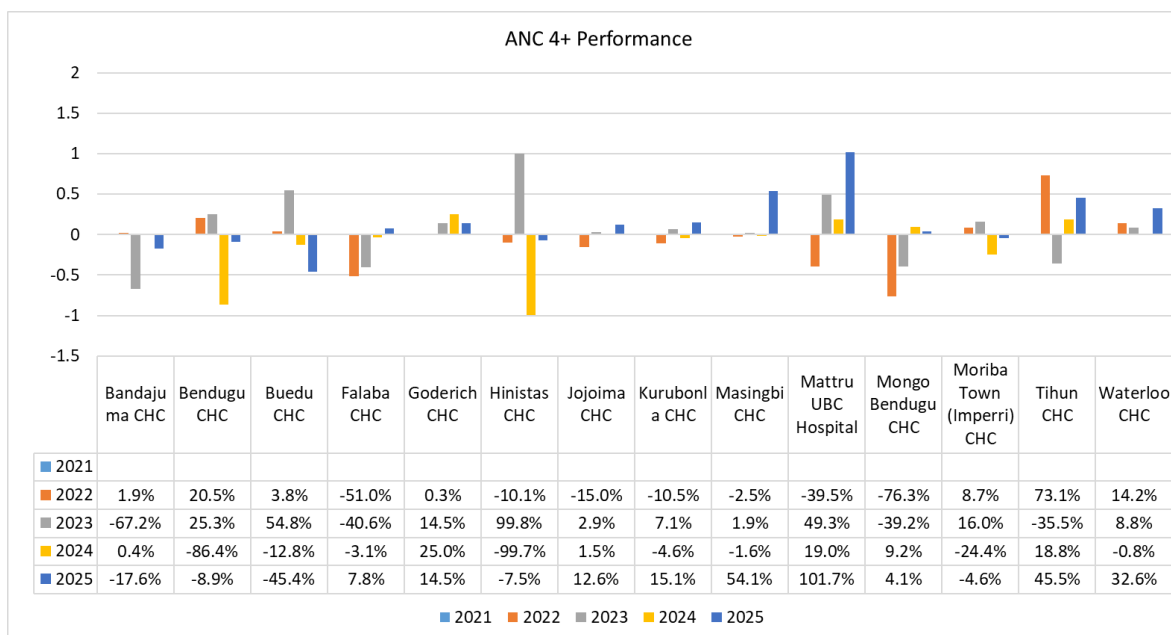
Figure 3:ANC4+ Coverage trend



Secondary data from the 14 Hubs indicate that the number of pregnant women completing at least four antenatal care (ANC) visits increased from 6,049 in 2021 to 7,164 in 2025. Annual changes during the period show: a 5.9% decline between 2021 and 2022, a 7.0% increase between 2022 and 2023, an 11.4% decline between 2023 and 2024, and a subsequent 14.6% increase in 2025. Overall, the four-visit ANC caseload rose by 18.5% over the 2021-2025 period.

⁷ QEHSSSP Project Result Framework Report

Figure 4:ANC4+ Performance at hub level



Across facilities and time periods, the proportion of women completing four or more antenatal care (4+ ANC) visits shows substantial variation. Several facilities demonstrated notable improvements in 2025, while others experienced persistent low performance or extreme volatility.

Clear positive improvement: Matru, Masinghbi, Tihun, and Waterloo recorded consistent positive performance between 2025, indicating recent gains in 4+ ANC attendance. Chronic low-performing facilities: Mongo Bendugu CHC, Bandajuma CHC, Jojoima CHC, and Moriba Town (Imperri CHC) show sustained declines or extreme instability, classifying them as low-performing and unstable. Moderate / mixed performers: Goderich CHC, Bendugu CHC, Buedu, Kurubonla CHC, and Hinistas CHC showed mixed results, periods of improvement interspersed with declines making their overall trajectory unclear.

Some hubs experienced dramatic percentage swings (for example, nearly +100% followed by -99.7%), likely driven by very data quality issues; these swings render percentage-based performance unreliable for interpretation at those sites.

Specific facility trajectories:

- Falaba CHC: Multi-year decline followed by a slight recovery in 2025, suggesting partial rebound but remaining below optimal levels.
- Mongo Bendugu CHC: Chronic low performance across multiple years with some recovery but still a very low absolute trajectory (2022: -76.3%; 2023: -39.2%; 2024: +9.2%; 2025: +4.1%).
- Overall concerning trend in Falaba: facility-level trend showing large year-to-year percent changes (2022: -51.0%; 2023: -40.6%; 2024: -3.1%; 2025: +7.8%), indicating long-term underperformance requiring program attention.

Implications for program management and M&E

Facilities with sustained low performance (Mongo Bendugu, Bandajuma, Jojoima, Moriba Town) should be prioritized for targeted interventions-supervision, supportive mentoring, supply checks, community outreach to address demand-side barriers, and refresher training for ANC service delivery.

1.2. Skilled Birth Attendance

The project recruited and deployed additional 60 clinicians (midwives, SECHNs, SRNs) to hub facilities in order to increase facility-level capacity to provide skilled maternal care.

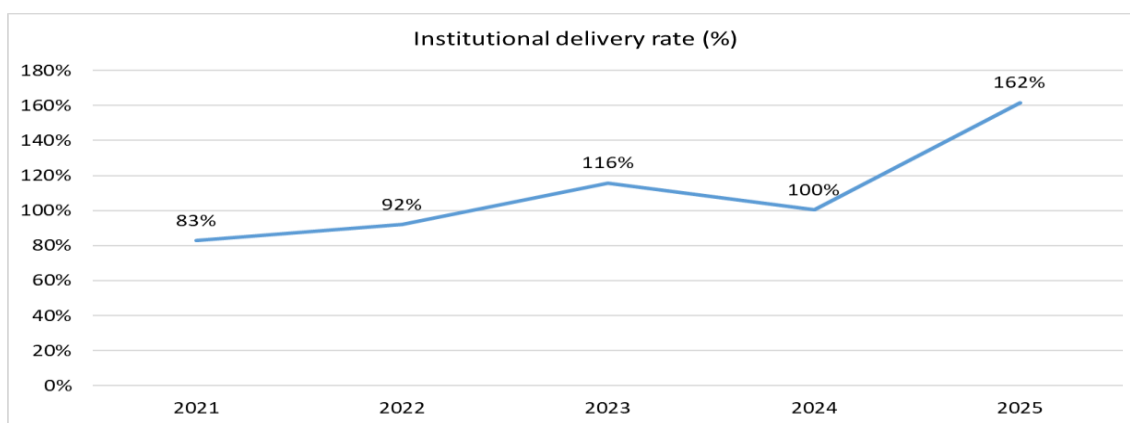
As a result, skilled birth attendance in the target districts has shown sustained and improving performance across the reporting period, consistently meeting or exceeding targets. Trends (deliveries attended by skilled health personnel)

- ✓ 2022: 44,872
- ✓ 2023: 66,714
- ✓ 2024: 68,700
- ✓ 2025 (Q3): 62,616

Overall trajectory at the district level indicates significant year-on-year increases from 2022 to 2024. The figures for Q3 2025 suggest a sustained strong performance when compared to baseline metrics and established targets⁸.

⁸ Institutional delivery = delivery by skilled health personnel/expected pregnant women

Figure 5: Average Institutional Delivery rate for 14 hubs



Source: DHIS2⁹

Overall variability: Skilled birth attendance at hub-level facilities shows marked year-to-year variation across facilities and districts, indicating uneven service utilization and/or recording practices.

High-growth facilities: Waterloo (CHC) and Goderich CHC- both with city status, recorded the largest year-on-year percentage increases in births attended by skilled personnel.

- 📊 Waterloo CHC: Year-on-year increases of 401% (2021), 511% (2022), 614% (2023), 623% (2024) and 1,258% (2025).
- 📊 Goderich CHC: Year-on-year increases of 177% (2021), 176% (2022), 166% (2023), 104% (2024) and 178% (2025).

Low-performing facility with similar status: Matru UBC Hospital, which shares city status with the high-growth CHCs, recorded substantially lower skilled births over the same period: 42% (2021), 39% (2022), 46% (2023), 48% (2024) and 43% (2025).

Implication:

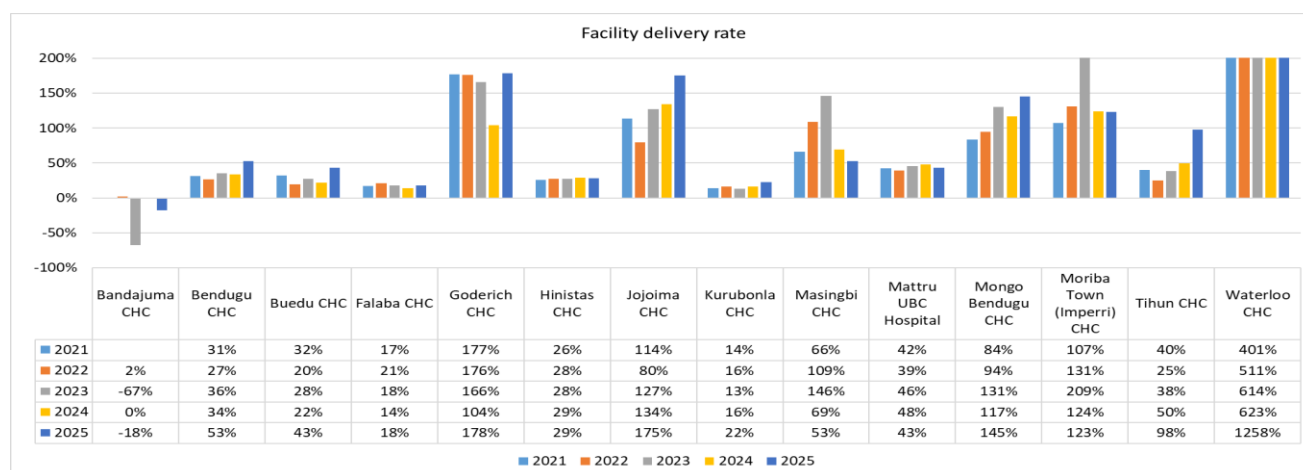
- ✓ Urban or city-status effect: The three CHCs with city status are expected to attract higher delivery volumes due to larger catchment populations, greater accessibility, and higher service demand. The very large increases at Waterloo and Goderich are consistent with this expectation and may reflect actual increases in facility deliveries, successful demand-generation or referral patterns, or improvements in data capture.

Implications for facilities with low delivery counts (eg Matru UBC and the others)

- Service readiness assessment: Conduct a rapid facility assessment of staffing levels (skilled birth attendants), essential obstetric supplies and equipment, operating hours, and referral capacity. Low service readiness would likely suppress the facility's ability to attract and manage deliveries.
- Referral/transport solutions: If geographic or transport barriers exist, strengthen ambulance/referral mechanisms, community transport schemes, or collaborate with local authorities to improve access during labour.

⁹ Institutional delivery = delivery by skilled health personnel/expected pregnant women

Figure 6: Hub facility delivery rate



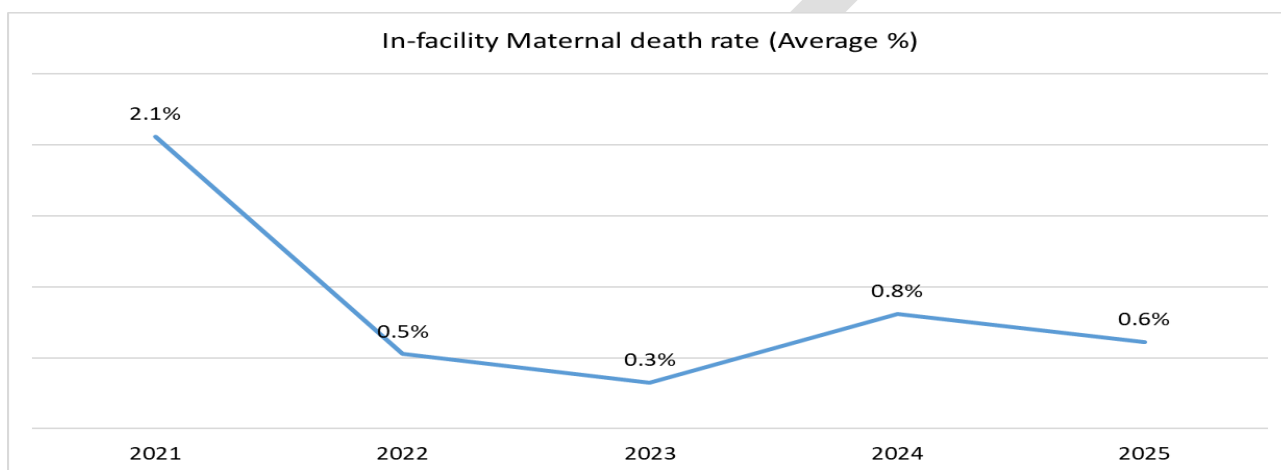
Implication: The variations in percentages indicate significant increases and decreases in skilled birth attendance, pointing to potential shifts in service utilization, access, or the accuracy of reporting at the facility or district level. Facilities demonstrating sustained positive changes over several years may indicate strengthened service delivery initiatives, better community engagement, or successful project implementations. On the other hand, districts or facilities experiencing significant negative changes may need a focused assessment to identify the root causes, including resource deficiencies, staffing limitations, or external factors impacting access. The year-on-year changes observed underscore the advancements made as well as the ongoing challenges in enhancing skilled birth attendance. This emphasizes the importance of ongoing monitoring, focused support, and flexible management strategies within the QEHSSSP implementation framework.

1.3. Maternal and Child Mortality

At the district levels, the Project Implementation Unit (PIU) confirmed that maternal mortality is monitored at the district level rather than by individual facility as designed by the project, and it is a non-DHIS indicator. The project focused on the timely maternal death review in the target implementing districts. District-level maternal death counts for the project areas are 132 in 2022 (baseline at the start of implementation); 110 in 2023 (17% decrease from baseline); 110 in 2024 (no change from 2023); and 90 by Q3 2025

(18% decrease from 2024). Overall, these figures represent a 32% reduction in maternal deaths between the 2022 baseline and Q3 2025. *These trends are aligned with the project results framework and would have been captured more clearly had the assessment applied that framework. The district counts reported by the PIU are consistent with official, authorized data published by the Ministry of Health and partner agencies (WHO, UNFPA, UNICEF).*

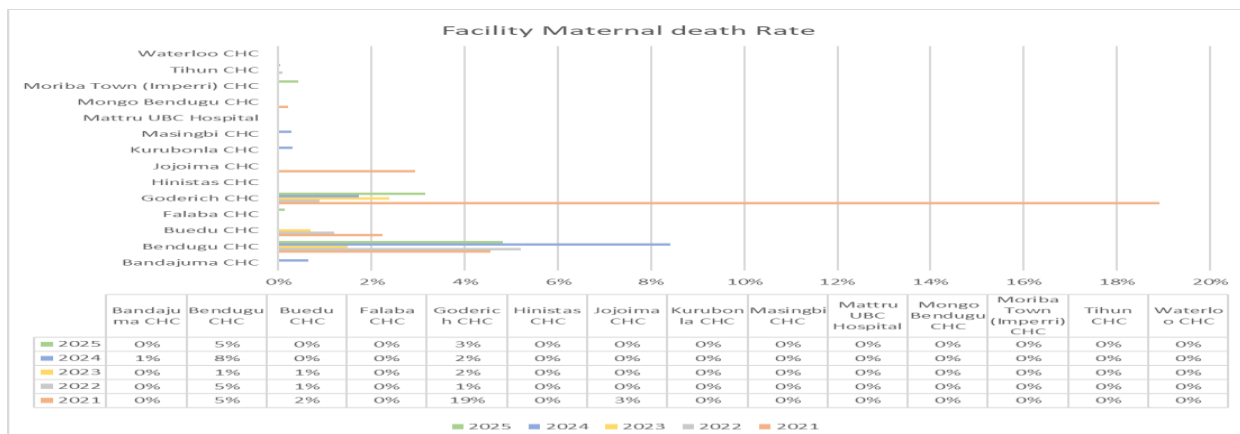
Figure 7: Maternal Mortality (Facility Outcomes)



The average maternal mortality across the QEHSSSP hubs greatly decreased by 0.5% from the 2021 baseline (2.1%). Although below the project baseline, we observed an increase in maternal death rates in the facilities on average by 0.8% in 2024 and 0.6% in 2025; these are above the 2022 and 2023 achievements.

Between 2021 and 2025, the project recorded 139 cumulative infacility maternal deaths across all hubs. Annual trends show an increase in absolute deaths in the most recent two years, with 18 additional deaths recorded in 2024 and 25 in 2025. The rise in absolute maternal deaths in 2024-2025 signals deterioration in outcomes that warrants further investigation into cause, location (facility vs. community), and contributing health-system factors.

Figure 8: Facility Maternal death rate

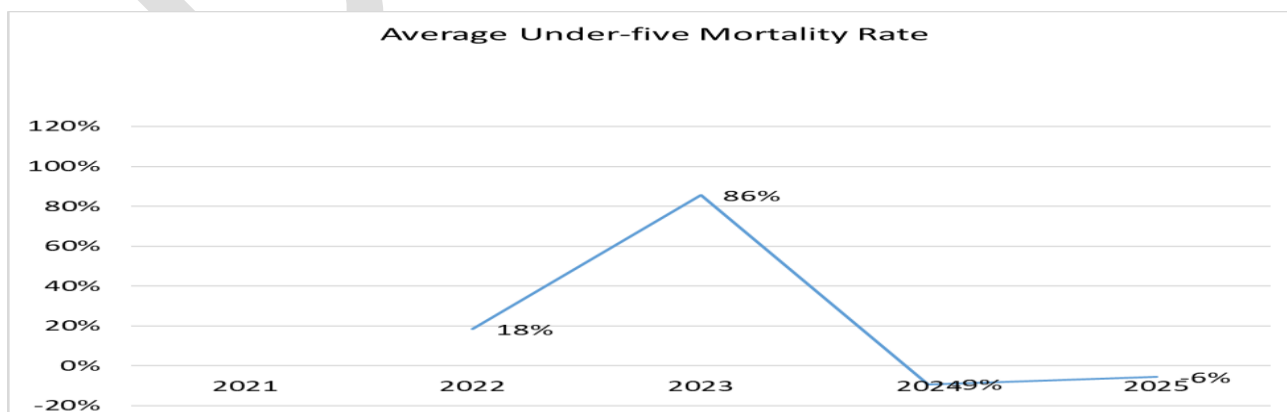


Under-5 Mortality

The under-five mortality was estimated as the proportion of estimated surviving infants who died in the hubs through the following causes:

- ✚ Child death - Cause unspecified 01-59 months
- ✚ Child death - Diarrhoea 01-59 months
- ✚ Child death - HIV 01-59 months
- ✚ Child death - Malaria 01-59 months
- ✚ Child death - Malnutrition 01-59 months
- ✚ Child death - Other specified causes 01-59m
- ✚ Child death - Pneumonia 01-59 months
- ✚ Child death - Trauma 01-59 months

Figure 9: Average under five mortality rate

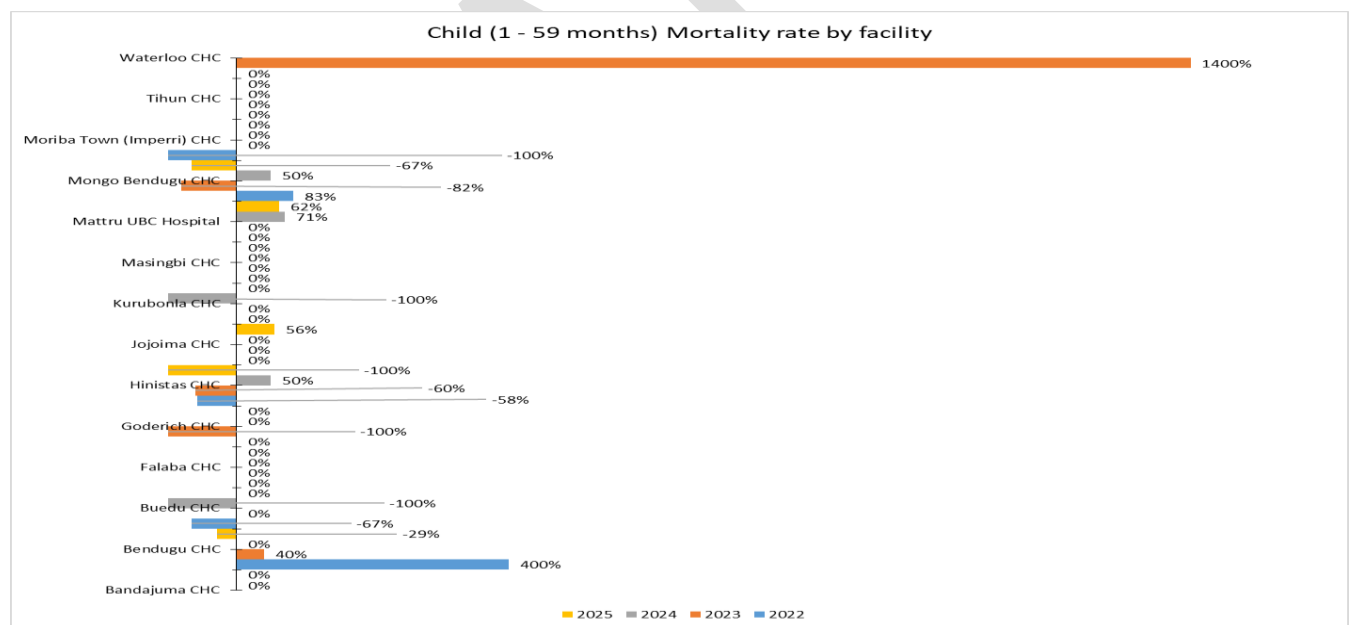


Facility-based under-five mortality increased by 18% in 2022 and by 86% in 2023, indicating a substantial deterioration in child survival outcomes. Following targeted quality improvement and service strengthening interventions, mortality declined by 9% in 2024 and a further 6% in 2025. Although these reductions suggest improving performance, continued efforts are required to sustain gains and return mortality levels to pre-2023 trends.

Under five mortality rate across the hubs

The overall rise in child mortality from 2021 to 2024, along with a minor decline in 2025, highlights significant weaknesses in pediatric healthcare systems. The identification of Matru UBC CHC as a persistent hotspot and the sudden peak and drop in Goderich indicate ongoing localized issues that remain unaddressed by the wider project initiatives.

Figure 10: Child mortality rate per hub



1.4 Immunization Coverage

At the District level, Children aged 0-11 months who received the third dose of pentavalent (Penta) vaccine in target districts (number and percentage).

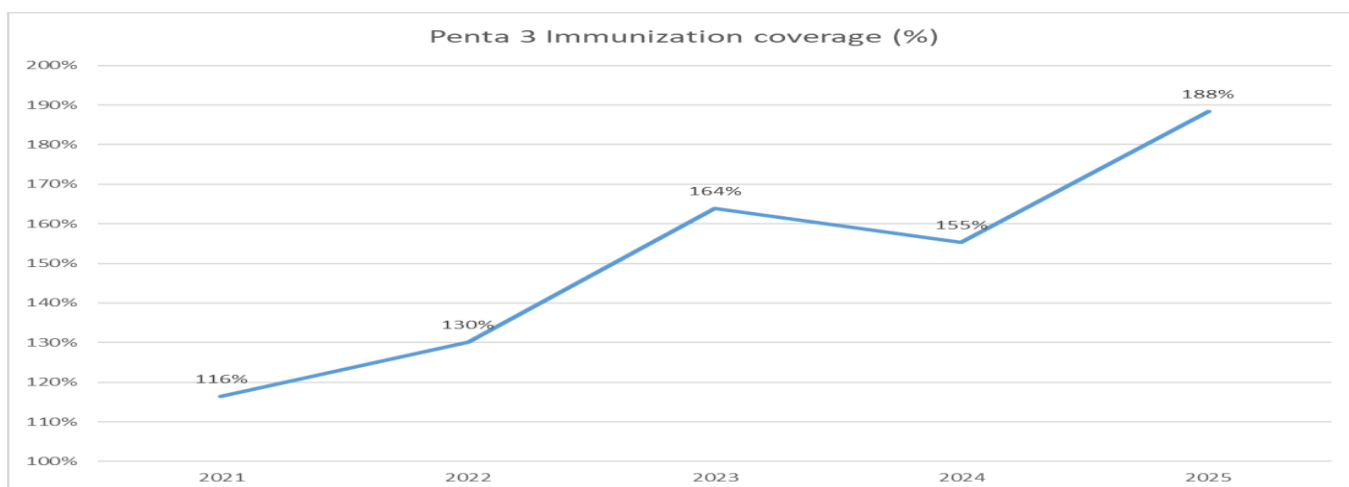
- ✓ Project results:
- ✓ 2022: 59,930 (87% of target[SM1])
- ✓ 2023: 95,504 (111% of target)[SM2]
- ✓ 2024: 93,514 (98% of target)[SM3]

✓ 2025 (Q3): 79,913

The indicator has consistently met or exceeded annual targets, achieving over 100% in 2023 and close to target in 2024.

Cumulative hub-level coverage increased from 4,753 in 2022 to 6,528 in 2025, representing a 37% rise, indicating sustained improvement in Penta3 uptake across the project districts¹⁰

Figure 11: Average Penta 3 Immunization coverage



Monitoring Findings: immunization coverage (children 0–11 months)

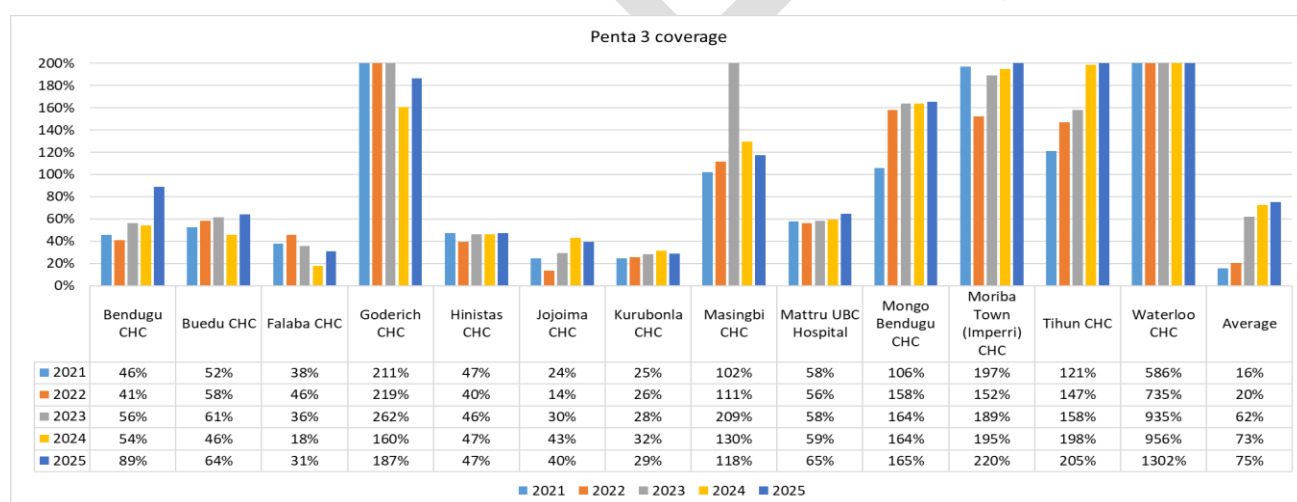
- ✚ **Scope:** analysis focused on children aged 0-11 months who were fully immunized, using routine facility-level monitoring data.
- ✚ **Key positive performers:** Mattru CHC and Masingbi CHC recorded substantial gains in full immunization coverage during 2022-2023. Goderich CHC achieved its peak coverage in 2024-2025.
- ✚ **Variable performers:** Tihun CHC and Mongo CHC showed moderate to high increases in coverage at different points in the review period; however, their trajectories were not consistent year-to-year, indicating fluctuation in program effectiveness at these sites.
- ✚ **Underperformers:** Bandajuma CHC and Moriba Town CHC experienced minimal gains or declines in specific years, signalling persistent operational challenges or underperformance that require investigation.
- ✚ **Short-term trend (2023-2024):** Percent changes between 2023 and 2024 were generally minimal across most facilities, suggesting a short-term stagnation or plateau in progress.

Interpretation and implications

¹⁰ Project Result Framework

- ❖ The concentrated improvements at Mattru and Masingbi in 2022-2023, followed by Goderich's later peak, indicate that targeted interventions or contextual factors produced measurable gains but that these gains were not uniformly sustained across locations.
- ❖ Fluctuating trends at Tihun and Mongo point to inconsistent implementation fidelity, supply or staffing variability, or demand-side factors (e.g., community outreach) that differ by year.
- ❖ Minimal or negative changes at Bandajuma and Moriba Town highlight sites that should be prioritized for rapid root-cause analysis, focusing on cold-chain integrity, vaccine stock-outs, staffing levels, data quality, and community access barriers.
- ❖ The near-flat change from 2023 to 2024 across most centres suggests the current program approaches may have reached a performance ceiling; without adaptive measures, further improvements will be limited.

Figure 12: Penta 3 Coverage per hub



Implications - The significant differences in immunization coverage suggest a lack of uniformity in project effectiveness across various districts and health centers. A limited number of sites exhibited significant enhancements. The observation that numerous others displayed stagnant or declining trends indicates potential challenges in service delivery, outreach efforts, or local conditions influencing uptake. The stagnation observed in 2023–2024 indicates a possible program bottleneck, signs of fatigue, or obstacles hindering ongoing progress. If left unaddressed, this could jeopardize the overall immunization objectives for the QEHSSSP.

1.5. Nutrition Services (Severely Acute Malnutrition - SAM)

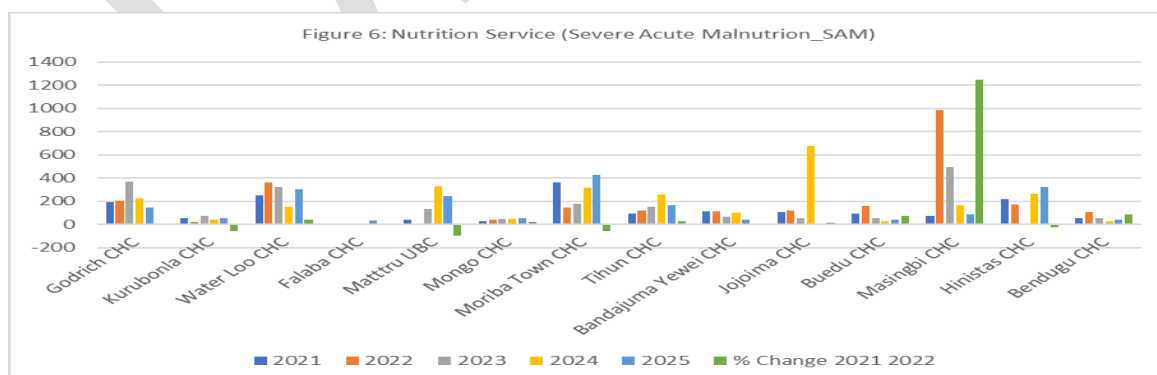
Severe Acute Malnutrition (SAM) case load and outpatient therapeutic programme (OTP) outcomes

- ✓ SAM case-finding: The number of children screened and identified with SAM at hub level rose steadily over the review period, from 2,107 in 2023 to 2,669 in 2024 and 3,447 in 2025, representing a cumulative increase of 63.6% between 2023 and 2025. This upward trend indicates growing SAM detection and/or increasing incidence in the catchment population.
- ✓ OTP cure rate: OTP performance showed marginal improvement in 2024, with the cure rate increasing from 89% in 2023 to 90% in 2024 (+1 percentage point). However, performance deteriorated in 2025 when the cure rate declined to 86% (-4 percentage points compared with 2024), falling below the programme's 2023 level and commonly used international minimum standards for OTP effectiveness.

Interpretation and implication

- The rising number of SAM cases combined with the 2025 decline in OTP cure rate signals mounting pressure on treatment services and a potential reduction in programme effectiveness. Increased caseloads may have strained resources (staffing, ready-to-use therapeutic food, follow-up capacity), contributing to the lower cure rate in 2025.
- These trends underscore the need to strengthen prevention strategies (community screening, growth promotion, infant and young child feeding, food security and social protection measures) alongside measures to restore and sustain high-quality OTP services¹¹.

Figure 13: Nutrition Services (Severely Acute Malnutrition)



¹¹ cure rate = cured/total exit (total discharged)

The notable peaks observed at Masingbi could indicate a potential outbreak, a marked improvement in case detection, or an expansion of programmatic outreach at the facility. Nonetheless, such an outlier may also indicate potential reporting errors or data quality concerns, necessitating additional validation. The observed stability or low coverage at numerous sites could suggest either successful management of SAM or potential deficiencies in detection and outreach efforts. Facilities exhibiting minimal or declining growth should be prioritized for enhanced oversight and additional analysis. These patterns prompt essential enquiries regarding the fundamental factors at play, be it alterations in service delivery, demographic changes, or heightened community involvement. The differences observed among CHCs underscore ongoing disparities in SAM service coverage, potentially influencing the overall impact of the project.

The voice of the service user:

"Whenever I bring my malnourished child to the clinic, they give us only a small amount of Plumpy-Nut, but write down a much larger quantity on the card. I watch my child grow weaker every day, while the help we so desperately need disappears into lies and false records"- ***A mother with a malnourished child***

The community testimony provided offers a powerful insight into the patient experience and underscores the importance of a predictable supply chain for therapeutic foods. The fluctuations in data present a challenge for precise planning and resource allocation. Strengthening the reliability of both the supply chain and the data reporting systems will be crucial to fully realizing the potential of these nutrition interventions and ensuring that services consistently meet community needs, thereby supporting child survival and development.

Nonetheless, The PIU responded that at the time of the assessment, facilities experienced temporary shortages of ready-to-use therapeutic food (RUTF/plumpy'nut) pending an anticipated UNICEF delivery the following month. UNICEF subsequently completed procurement and distribution on behalf of the project; adequate stocks to cover until the

next procurement cycle have now been received at all project health facilities, with surplus inventory secured in district medical stores. Management of moderate and severe acute malnutrition (MAM and SAM) is being conducted effectively across all project-supported facilities.

1.6. Health Promotion, Nutrition Services & Community Health Workers (CHWs)

The feedback from respondents indicates that while health promotion activities are underway, in areas like nutritional screening, provision of therapeutic feeds like Plumpy Nut, and breastfeeding promotion, there is an opportunity to enhance their reach and impact, as a significant portion of participants (30%) felt these efforts were inadequate. This sentiment highlights areas for improvement, particularly in the allocation of resources, staffing, and materials for community outreach.. Moreover, outreach frequency remains limited due to transportation issues and a scarcity of educational materials, compounded by insufficient staff training. Strengthening these initiatives through enhanced resources and training is critical to reducing malnutrition and improving maternal health outcomes. Of great concern though is that eight (8) out of ten (10) locations face operational challenges that negatively impact project beneficiaries. A lactating mother with a sick child received less Plumpy Nut than recorded on her ration card, highlighting discrepancies and unfair treatment during distribution as she lamented:

" Each inadequate Plumpy Nut I provide to my child carries a profound sense of unrealized potential that burdens my heart. I witness my child's decline before my eyes due to the inadequate supply of plumpy nut available to us. The assistance I urgently need to revive my child is caught in a web of dishonesty by those who were supposed to provide help."

This case illustrates how gaps in supply management affect the most vulnerable population and undermines the support intended by the project.

The PIU reported that the PHC program comprises approximately 1200 CHWs and 145 Peer supervisors operating within the project districts. According to the report presented, there are 179 health facilities (including hubs and spokes) across five project districts that do not have a corresponding community health worker assigned to each facility. The

deployment of 179 health workers in the Community Health Worker (CHW) program at a ratio of 1:1 represents a significant weakness in the establishment of community-based healthcare. The distribution of these personnel poses a challenge to attaining equitable coverage. The distribution appears to be unproportional. This situation presents a strategic opportunity to evaluate and enhance the distribution of CHWs, ensuring that every community has access to this essential connection to the formal health system in QEHSSP locations¹².

The PIU clarified that the RUTF referenced originates from national general supplies and is not linked to the project. QEHSSSP plumpy'nuts were distributed between October and December 2025. In any case the Ministry regards the issue as serious and would put measures in place to enable targeted investigation and appropriate mitigation measures.

1.7. Referral Pathways & Service Access

Responses from the PIU indicate that under the QEHSSSP, the Ministry procured 14 new ambulances and refurbished six existing vehicles, which were allocated to all facilities offering 24-hour services. The project also supported recruitment of more than 60 personnel-including ambulance drivers, paramedics, and referral coordinators-who facilitate ambulance operations across these facilities.

In addition, the project provides ongoing operational inputs for the ambulance system, including essential medical equipment and drugs, fuel, communication tools, and other routine support, and maintains feedback mechanisms to monitor service performance.

Progress against the project's referral indicator is partial: there has been an increase in deliveries referred from spoke facilities to hubs/hospitals, but the target has not yet been fully achieved.

The feedback from beneficiaries indicates a lot of progress in service access. Forty-six percent of in-charges and 70 percent of DMO reported partial functionality. This is a positive step forward but maintaining these gains will require addressing ongoing operational challenges particularly vehicle maintenance and fuel availability. Important

¹² Annex 9: PHU numbers in hub & spokes with CHWs

areas for development remain infrastructure needs, including reliable power and sufficient staff housing, to enable the provision of consistent, high-quality care at all times.

“The Ministry acknowledges the challenges highlighted in the report like maintenance, fuel, housing etc. which had been mitigated with the use of framework contracts for maintenance, direct supply of fuel-by-fuel dealers and community engagement and awareness which has helped in the acceptance and housing of staff”. The PIU responded!

Component Two: Strengthening National Health Systems

This component focused on the foundational pillars of the health system. The findings highlight significant areas for development to ensure the sustainability and effectiveness of health services. As a facility staff member simply puts it: *“The rehabilitation of the hospital has not been done yet. The drug supply is inadequate. Observation and postnatal beds are not enough.”*

2.1. The Human Resources for Health (HRH)

Figure 14: QEHSSS Training Dashboard



Source: QEHSSSP PIU's progress report

The response from PIU in relation to capacity-building activities and outcomes suggests that between 2023 and May 2026, the QEHSSSP-supported capacity-building programme maintained continuous delivery of in-service and pre-service training to strengthen clinical and public-health competencies across project facilities.

Key outputs reported by the PIU:

- ❖ Total trainees: 2,479 health workers trained under the project (2023 to 2025).
- ❖ Partners In Health (PIH) supported trainings: 2,362 health workers trained across the five project districts in the following modules: IMNCI, EmONC, IOCG, short- and long-term family planning, IPC, MPDSR, and AYFS.
- ❖ Multiple training exposures: 458 participants from Hubs, 1,577 from Spokes, and 445 from district hospitals, DHMTs and other CHC staff received one or more of the listed trainings (some individuals received training in multiple disciplines).

Pre-service and allied health training

- ✓ Physician Assistants: 301 students currently enrolled and supported through the School of Clinical Sciences (project-funded).
- ✓ Para-veterinary training: 23 para-veterinary students fully funded and trained through MAFS (Njala University).

Curriculum development

- ❖ CoHMAS curriculum development completed for dentistry, public health, medico-surgical nursing, midwifery, and paediatrics to support longer-term workforce strengthening.

Observed needs and actions

- ✚ Training needs are routinely assessed and used to plan subsequent rollouts to project staff and other health personnel.
- ✚ Continued delivery of targets in-service and pre-service training aims to improve the quality of care across all project facilities.

The monitoring team noted that a strengthened and well-distributed workforce is essential for equitable and high-quality service delivery. Focusing on strategic training and addressing staffing gaps will be crucial for the successful implementation of all health interventions. The findings indicate that human resource capacity is a key area for development, identified by 40% of respondents as a challenge. Furthermore, a majority of staff (83%) indicated that training opportunities could be enhanced to better meet their needs. The distribution of training in 2023 was concentrated in a few facilities. A total of

2,362 health care workers received training across 5 distinct conducted between 2023 and 2025 across all hubs and spokes in the five selected districts¹³

Implication for M&E

- ❖ Continue to track participant competency gains and clinical practice changes by cadre and facility type to measure training effectiveness.
- ❖ Continue to Monitor coverage (proportion of target cadres trained), training frequency per individual, and linkage between training and service quality indicators (e.g., EmONC signal functions, IPC compliance, family planning uptake).

2.2. Health Infrastructure & Equipment

Continued development of infrastructure and equipment is fundamental to enabling staff to deliver services safely and effectively, and to encouraging community utilization of health facilities.

Progress on infrastructure upgrades is ongoing, with 36% of facilities rehabilitated and 21% with new construction.

Waste management is still a crucial opportunity to improve environmental hygiene and safety procedures at all project locations. An early disbursement of USD 800,000, or 53% of the anticipated amount, was noted under the line item for waste disposal. The Centralized Biomedical Treatment Waste Management Facility was not the only use of this USD 800,000, according to PIU verification. Instead, the sum was repurposed to a larger project sub-component that encompassed several tasks. In the cost category "Emergency Preparedness and Response and Waste Management," the project's contribution to the Government of Sierra Leone through the National Public Health Agency (NPHA) for emergency preparedness and the country's response to the Mpox outbreak accounts for the greatest portion of the disbursement. At the beginning of this monitoring process this was thought to be funding for the Centralized Biomedical Treatment Waste Management Facility due to insufficient explanation. For a thorough breakdown of the USD 800,000 by activity and expense category, see the table.

¹³ Annex 8: PIH Database for QEHSSSP project

Figure 15: World Bank Unified Financial Management Reporting Portal statement for clarity.

FINANCIAL UPDATE FOR THE SIERRA LEONE QUALITY ESSENTIAL HEALTH SERVICES AND SYSTEMS SUPPORT PROJECT - QEHS SSP																	
Component Number	Description of Components	Budget				Disbursed Amount to Date								Percentage Variates			Variance Explanation
		IDA Grant	GFF Grant- EWEC (7267)	GFF Grant- WCA (7266)	Total (World Bank)	IDA Grant	GFF Grant- EWEC (7267)	GFF Grant- WCA (7266)	Total (World Bank)	Summary of activities Budget expended on	IDA Grant	GFF Grant- EWEC	GFF Grant- WCA				
		Total USD	Total USD	Total USD	Total USD	Total USD	%	Total USD	%	Total USD	%	Total USD	%	%	%	%	
2	Strengthening National Level Systems	9,423,514	1,511,246	-	10,934,759	2,613,631	28%	800,000	53%	-	0%	3,413,631	31%	72%	47%	100%	
2.2	Strengthening epidemic preparedness and managing medical waste	-	1,511,246	-	1,511,246	-	0%	800,000	53%	-	0%	800,000	53%	100%	47%	100%	

Code	Description	Original Budget (1)	Virements / Supplementary (2)	Total Budget (1) + (2)	Advances / Commitment (3)	YTD Actuals (4)
304042201	2.2.1: strengthen systems to prevent, detect and respond to infectious and vector-borne disease outbreaks	995,000	-	995,000	-	825,457
30425220101	2.2.1.1 Conduct regional consultative meetings on draft SOPs, Policy and Action Plan for National Public Health Agency (NPHA)	39,000	-	39,000	-	55,264
30425220102	2.2.1.2 Conduct validation meetings of SOPs, Policy and Action Plan for National Public Health Agency (NPHA)	30,000	-	30,000	-	29,502
30425220103	2.2.1.3 Support to NPHA strategic plan implementation	196,000	-	196,000	-	193,765
30425220104	2.2.1.4 Build capacity of NPHA staff	30,000	-	30,000	-	8,956
30425220105	2.2.1.5 Support to six weeks mpox response strategy	-	-	-	-	537,971
30425220105	2.2.1.5 Support to six weeks mpox response strategy	700,000	-	700,000	-	-

2.3. Pharmaceutical Supply Chain

Ensuring a consistent and reliable supply of essential medicines remains a priority as more than half of the respondents (53%) reported major deficiencies in drugs and medical supplies.

Despite improvements in the provision of free healthcare drugs, concerns persist about stock adequacy and frequent stockouts which sometimes force patients to purchase medications elsewhere. Community expectations remain high for a sustainable and uninterrupted drug supply through the QEHS SSP. An informed beneficiary stated, "The last supply of QEHS SSP drugs occurred in October 2024, and there has been no subsequent supply since that time." A reliable medicine supply is a cornerstone of quality healthcare. Strengthening the supply chain is essential for maintaining community trust and ensuring that health consultations lead to positive outcomes.

The response from the PIU indicated that at the time of the assessment, pharmaceutical consignments had arrived in-country but were pending district-level distribution. Subsequent reports from the Ministry confirm that full distribution to all districts has now

been completed. The Ministry recommended that NaMEA undertake a brief verification-either through remote verification methods or targeted field follow-up-to update the assessment findings to reflect the completed distribution.

“As of October 2025, and on to date, all QEHSSSP-supported facilities maintain adequate stock levels of the full essential drug list”. The M&E specialist concluded.

2.4. Implementation of Health System Models

These models offer promising approaches for health system strengthening. Their effectiveness will be increased by ensuring they are supported by adequate resources and that all staff are well-informed and engaged.

Hub-and-Spoke Model:

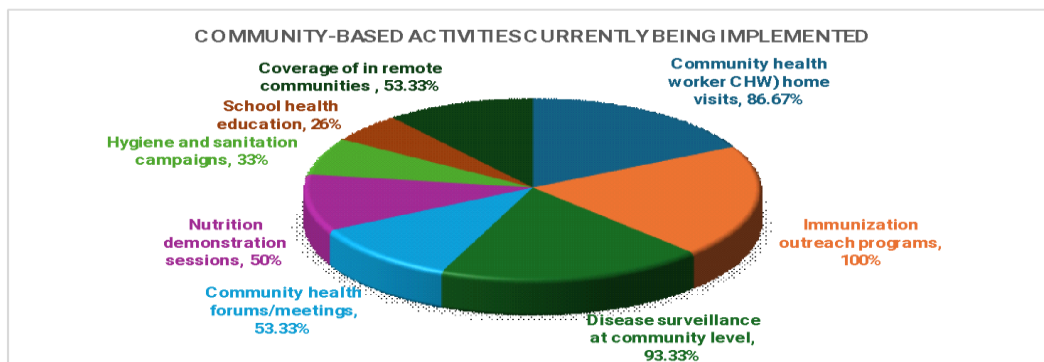
- The implementation of this model provides a valuable framework for building a more integrated health system. (See Annex 11). Feedback from District Medical Officers (DMOs) indicates that its full potential can be realized by concurrently addressing foundational needs in supplies, infrastructure, and human resources.
- The challenges identified as obstructing the comprehensive implementation of the Hub and Spokes model primarily pertain to limitations in resources. The primary challenges identified include a shortage of essential supplies and inadequate infrastructure, evidenced by high reporting rates from DMOs and Facility In-Charges at 70% and 90%, respectively. Further challenges identified are a shortage of human resources, reported by 40% of respondents, alongside insufficient training and funding, each noted by 33.33% of participants. The significant bottlenecks identified are largely rooted in resource constraints, highlighting systemic deficiencies in supply chain management, infrastructure investment, workforce capacity, and funding availability. The identified deficiencies clarify the previously noted partial functionality and underscore the necessity for focused interventions

2.5. Community-Based & Specialized Services

Since the project’s operationalization in 2023, the PIU confirms that Facility Management Committee (FMC) meetings have been convened monthly at each hub facility.

Documentation supporting these meetings- including minutes - is maintained at the respective hub offices and is available for verification.

Figure 16: Community based activities being implemented



The figure reveals that immunization outreach, disease surveillance are at least 93%, and community health worker (CHW) home visits are being delivered at highest levels, while hygiene campaigns and school health education show much lower coverage, highlighting significant coverage gaps, especially in remote areas. Challenges such as poor road conditions, limited resources, lack of incentives for CHWs, and insufficient outreach materials hinder effective community sensitization and service delivery. However, Community Engagement and Facility Management Committees (FMCs) are active in most facilities, collaborating with health staff to improve services and resolve community concerns, demonstrating strong community participation. *Nonetheless, there was no evidence to support that the Monthly Facility Management Committee (FMC) meetings were occurring as indicated by the PAD, which anticipated 45 meetings by the fourth year of project implementation.*

School Health Services:

School health services represent a significant opportunity for promoting wellness among youth. Current functionality is limited, indicating a potential area for future investment in space, staffing, and dedicated materials for school-based programs.

Nonetheless responses from the PIU indicated as follows:

- Issue identified: Procurement and delivery experienced a delayed start, which temporarily constrained rollout of the school health program activities in targeted schools.
- Mitigating actions: The Ministry and implementing partners conducted multiple teacher training sessions to strengthen readiness and ensure schools are prepared to implement a comprehensive school health program upon receipt of supplies.
- Current status: UNICEF-procured school health kits have arrived in-country and are currently undergoing customs clearance and port-handling procedures prior to distribution.
- Monitoring and next steps: The project's monitoring team is actively overseeing clearance and logistics processes. Based on current timelines, distribution to selected schools is scheduled for completion by June 2026, subject to timely port clearance and local transport arrangements.

Gender-Based Violence (GBV) Centers:

The PIU reported that the Ministry of Health, with support from the World Bank under the QEHSSSP, treats gender-based violence (GBV) interventions as core project activities.

Activities implemented:

- ❖ *Capacity building: Routine GBV training and awareness-raising sessions delivered by project staff and World Bank partners.*
- ❖ *Service readiness: Dignity kits and psychosocial support services have been distributed and activated for survivors.*
- ❖ *Accountability and access: Signage and a fully functional grievance redress mechanism (GRM) are in place to receive and manage GBV-related complaints.*
- ❖ *Facility support: Commitment from the Ministry to ensure one-stop centres in project areas remain fully operational.*

The monitoring team noted that the establishment of GBV centers is a critical step in providing comprehensive care. While progress has been made, there is still a need to support these centers in becoming fully operational and accessible to all who need them.

Component Three: Project Management, M&E, and Coordination

The findings here highlight opportunities to strengthen the project's operational backbone for more effective implementation.

3.1. Financial and Procurement Controls

Responses from the PIU indicate that financial management and procurement responsibilities are delegated to IHPAU and PIH for their respective activities. The Project Implementation Manual (PIM) establishes the project's financial management and procurement framework and defines roles and responsibilities.

The PIM outlines core financial management procedures, including annual work planning and budgeting, expenditure control, fund flow arrangements, bank reconciliation processes, accounting systems, regular financial reporting, preparation of financial statements, audit requirements, and project closure procedures. These provisions are intended to ensure fiduciary compliance, transparency, and timely reporting across implementing entities. The figure below summarizes the operational status identified in the World Bank's most recent project review, which rated Procurement and Financial Management as both satisfactory.

Figure 17: Project performance rating from the World Bank review

OPERATION STATUS	
Project Performance Ratings	
Operation Ratings	
NAME	LAST ISR RATINGS 24-Dec-24
Progress towards achievement of PDO	● Satisfactory
Overall Implementation Progress (IP)	● Moderately Satisfactory
Overall Risk	● Substantial
Overall ESS Performance	● Moderately Unsatisfactory
Financial Management	● Satisfactory
Project Management	● Satisfactory
Procurement	● Satisfactory
Monitoring and Evaluation	● Satisfactory

Perceptions from field monitoring across the five districts identified significant gaps in compliance at the district and 14 hubs. Financial control procedures were observed to be applied in only 40% of monitored instances, indicating weak adherence to required financial management practices at the field level. Procurement processes demonstrated even lower compliance, with documented adherence in only 33% of cases¹⁴.

Implication: Strong financial and operational systems are the foundation for effective project implementation. Strengthening these areas supports transparency, efficiency, and timely achievement of project goals.

¹⁴ Annex 7: Financial Update for the QEHSSSP

3.2. Coordination and Partnerships

A summary of Roles, Responsibilities and Coordination as highlighted by the QEHSSSP PIU

- ✓ Institutional framework: The Project Implementation Manual (PIM) defines roles and responsibilities across participating entities. The Chief Medical Officer (CMO) serves as Project Coordinator and technical head of the Ministry, providing overall technical oversight for all directorates.
- ✓ Implementing units: Key implementing units include the Integrated Health Program Administrative Unit (IHPAU) operating under the CMO, and program directorates such as Directorate of Planning , Policy and Implementation DPPI and Public Health and the Nutrition Directorate, which execute program activities at directorate level.
- ✓ Grant management and coordination: A Grant Management Specialist embedded in the project functions as the principal liaison between the World Bank, IHPAU, and implementing directorates, facilitating communication and grant-related processes.
- ✓ Annual planning and reporting: An Annual Work Plan (AWP) is prepared at the start of each year; implementing directorates submit activity plans and budgets (example: the Nutrition Directorate submits its annual budget, requests resources, implements nutrition activities, and reports on outputs and expenditures).

The monitoring team confirmed the existence of coordination mechanisms during the conference review of this report, conducted as part of the Results Monitoring and Evaluation Arrangements. The Project Implementation Manual (PIM) for QEHSSSP designates DPPI, the District Health Management Teams (DHMTs), and the M&E Unit of IHPAU as the primary focal points for M&E implementation. IHPAU is assigned responsibility for the project-level M&E system in accordance with the agreed implementation structure and results framework. A dedicated M&E team for both central and district levels was established at the conclusion of the final review of our monitoring activities. IHPAU collaborated with DPPI to ensure the monitoring data collected for this exercise is aligned with the indicators and reporting requirements of the Results Framework as reported through the national HMIS.

QEHSSSP Budget Management against results

The project is funded with a US\$40 million IDA grant and US\$20 million from the Global Financing Facility (GFF), totaling US\$60 million. The project had disbursed 42% at the time of review in September 2025, and 48% as of November 2025. The project is about to complete its third year of implementation, with a closing date in December 2027¹⁵.

¹⁵ Update from PMU

Budget Planned vs Disbursement Pattern

Funding Source	Planned Budget (US\$ Million)	Disbursed To Date (US\$ Million)	% Disbursed
IDA Grant	40.00	6.85	17.1%
GFF Grant - EWEC	10.00	4.41	44.1%
GFF Grant - WCA	10.00	8.46	84.6%
Total	60.00	16.71	29.0%

(Disbursement data as of December 2, 2024)

Financial Management and Disbursement Insights

- ✓ Overall financial management is rated satisfactory, with systems meeting World Bank requirements.
- ✓ Disbursement rates vary across funding sources, higher for GFF grants (especially WCA) compared to IDA.
- ✓ Expenditure tracking for 2024 shows about 41% utilization of the annual work plan budget by November 30, 2024.
- ✓ Foreign exchange loss was noted as approximately USD 1.98 million, signaling the need for continued monitoring and budget adjustment.
- ✓ Delays in procurement processes due to technical and administrative challenges have slowed down disbursements and project implementation.

Implications for Project Implementation

The disbursement rate of 48% after nearly three years indicates slower-than-expected financial execution impacting timely delivery of project activities.

Slower disbursement partly reflects initial challenges in operationalizing the hub-and-spoke model, procurement delays, and capacity constraints within decentralized health management teams.

Imbalanced disbursement especially in IDA funds requires urgent attention to increase financial execution to avoid underutilization of available resources before project close.

Planned expansion in service delivery, including rehabilitation of health hubs and scaling up of essential drug supply requires timely release and utilization of funds.

Continued financial and procurement capacity building, along with enhanced autonomy to district health teams, is critical to accelerate implementation.

Project reallocation plans aim to prioritize high impact activities and strengthen supply chain and referral systems to improve service delivery outcomes¹⁶.

Nevertheless, the Project Implementation Unit (PIU) reports an accelerated implementation phase. Key high-value activities-including facility rehabilitations and increased procurements of pharmaceuticals, medical devices, and laboratory equipment-are scheduled for execution in 2026. The PIU has committed over 35% of total project funds within the 2026 Annual Work Plan and Budget, positioning cumulative disbursements to exceed 80% by December 2026.

4. Recommendations and Conclusion

Conclusion

The QEHSSSP stands at a critical juncture. While it has demonstrably laid the foundation for improving health outcomes through strategic models and initial investments, the project is currently undermined by significant operational bottlenecks and systemic gaps. The rise in maternal deaths in some hubs, unpredictable service utilization, and persistent deficiencies in infrastructure, supplies, and coordination reveal a project facing challenges in translating its design into consistent, quality healthcare delivery. The window of opportunity to address these challenges is now. The recommendations outlined above provide a reasonable roadmap for action. By prioritizing data integrity, clarifying leadership, addressing critical resource gaps, and relentlessly focusing on the quality and accessibility of services for the most vulnerable, the QEHSSSP can still achieve its vital outcome of strengthening the country's health services and ensuring better health for the population.

Recommendations

This section consolidates all proposed actions from the monitoring assessment into a standalone set of recommendations, structured by thematic area to guide the future implementation of the Quality Essential Health Services Strengthening Project (QEHSSSP).

4.1. Overarching and Cross-Cutting Recommendations

1. **Data Quality and Evidence-Based Action:** Strengthen the data collection and reporting system immediately. Conduct regular data quality audits to ensure accuracy and consistency. This reliable data must then be actively used to identify problems, tailor interventions to specific CHC needs, and measure impact.
2. **Coordination and Governance:** Clarify and formally document the roles, responsibilities, and accountability lines for all implementing partners (e.g.,

¹⁶ QEHSSSP Additional Financing Request 1 Document, World Bank, June 2025 [documents1.worldbank](#)

IHPAU, DPPI, DFN, DHMTs). Establish a clear governance structure with a single designated entity for leadership and decision-making to eliminate current ambiguities.

4.2. Recommendations for RMNCAHN Service Delivery

1. Outpatient Service Utilization:

- ❖ Conduct triangulation: verify outpatient figures against facility registers, HMIS reporting, and any partner data to rule out reporting artifacts.
- ❖ Rapid facility assessment in hubs showing the largest declines to identify operational barriers (staffing levels, facility hours, drug/consumable availability).
- ❖ Community-level assessment (focus groups or short household surveys) to capture demand-side barriers and changes in care-seeking behavior.
- ❖ Review program inputs and timelines to identify any reductions in outreach, financing, or facility support coinciding with the 2024-2025 declines.
- ❖ Based on findings, implement targeted remedial measures: restore disrupted inputs, strengthen outreach and community engagement, and monitor monthly outpatient attendance to evaluate recovery.

2. **Antenatal Care (ANC) and Skilled Birth Attendance:** Conduct targeted investigations into the root causes of declining ANC attendance and skilled birth attendance in the worst-performing CHCs (e.g., Mongo, Bandajuma Yewei, Buedu). Develop and implement localized action plans that address barriers such as transport costs, community trust, and the quality of client-provider interactions.

3. **Maternal and Child Mortality:** Prioritize emergency obstetric and newborn care (BEmONC) training and resource allocation to identified mortality hotspots (e.g., Kurubonla, Water Loo, Mattru UBC). Ensure these facilities have the necessary drugs, equipment, and trained staff to manage complications.

4. **Immunization:** Stabilize the vaccine supply chain to prevent stockouts. Launch targeted community engagement and social mobilization campaigns to address vaccine hesitancy and improve uptake, especially in areas with low coverage.

Recommended actions

- ❖ Conduct facility-level rapid assessments at Bandajuma and Moriba Town to identify operational constraints (supply chain, staffing, outreach, and data integrity).
- ❖ Review and document the interventions implemented at Mattru, Masingbi, and Goderich during their improvement periods to extract scalable practices (training, outreach schedules, incentive structures).

- ❖ Implement quarterly triangulation of administrative coverage with spot household surveys in a sample of facilities (including Tihun and Mongo) to validate reported trends and identify demand-side barriers.
- ❖ Pilot adaptive interventions in plateauing facilities for 6 months (enhanced outreach, microplanning, or supportive supervision), with clear indicators and monthly monitoring to detect early impact.
- ❖ Strengthen routine data quality audits and introduce simple performance dashboards to detect declines early and trigger corrective action.

5. **Nutrition Services:** Verify the accuracy of SAM data and strengthen routine screening at the community and facility levels. Ensure a consistent, uninterrupted supply of therapeutic feeds (e.g., Plumpy Nut) and implement strict monitoring to ensure transparent and fair distribution to prevent leakage and misuse.

Severely Acute Malnutrition (SAM) case load and outpatient therapeutic programme (OTP) outcomes

- ✓ Conduct a rapid programme review to identify drivers of the 2025 cure-rate decline (stock-outs, staffing, case management adherence, referral and follow-up, data quality).
- ✓ Scale up preventive interventions at community level to reduce incident SAM (IYCF counselling, WASH, food assistance where appropriate, maternal nutrition).
- ✓ Reinforce OTP capacity-ensure uninterrupted supplies, refresher training for frontline workers, and support supervision to improve case management and follow-up.
- ✓ Strengthen routine monitoring: disaggregate OTP outcomes by hub, age, and admission type; track supply and staffing indicators; and set monthly targets to detect and respond to deterioration early.

4.3. Recommendations for Human Resources and Community Health

7. **Training and Deployment:** Decentralize and expand the training of health workers to include all CHCs, ensuring no facility is left behind. Focus on training specialized cadres such as midwives, nutritionists, and GBV counsellors. Optimize the deployment of Community Health Workers (CHWs) to ensure equitable coverage, particularly in underserved areas like Water Loo CHC, which currently has none.
8. **Health Promotion and Outreach:** Provide adequate and reliable resources for community outreach, including vehicles, fuel, and educational materials. Address

the lack of incentives for CHWs to motivate their work in community sensitization and service delivery.

4.4. Recommendations for Infrastructure, Supplies, and Systems

9. **Infrastructure Rehabilitation:** Accelerate the pace of facility rehabilitation and new construction. Prioritize completing outstanding work in the 64% of facilities where no rehabilitation has occurred to create a functional and conducive environment for service delivery.
10. **Medical Supplies and Supply Chain:** Establish a consistent and reliable pipeline for drugs and essential medical commodities to eliminate frequent stockouts. This includes finalizing and implementing a robust logistics management system. M-Supply could be an option.
11. **Referral and Ambulance Systems:** Implement a robust ambulance maintenance schedule and ensure a reliable fuel supply to prevent breakdowns and delays. Formalize and standardize referral pathways between hubs and spokes for seamless patient transfers.

4.5. Recommendations for Specialized Services

13. **School Health Services:** Strengthen collaboration between the health and education sectors. Invest in establishing well-resourced, dedicated school health clinics with trained staff to address the significant gap in adolescent and child health services.
14. **Gender-Based Violence (GBV) Response:** Urgently establish one-stop GBV centres in all target districts, staffed with trained personnel. Develop and disseminate clear intersectoral referral mechanisms to provide comprehensive support to survivors.

4.6. Recommendations for Management and Finance

15. **Financial and Procurement Controls:** Enhance training and oversight of financial and procurement procedures. Streamline approval workflows to reduce delays and ensure adequate staffing of procurement offices. Advance transparency through regular audits and capacity building.

ANNEXES

Annex 1: People Met



People Met.d

Annex 2: Questionnaire for Hub Facility In-Charges



Facility_QEHSSP_Qu
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Annex 3: Questionnaire for Key Informant Interviews



KII_QEHSSP_Based
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Annex 4: Questionnaire for partners



Partners_QEHSSP_Q
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Annex 5: Focus Group Discussion (FGD) Guide



FGD
tool_QEHSSP.doc

Annex 6: Questionnaire for IHPAU



IHPAU_QEHSSP_Que
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Annex 7: Financial Update for the QEHSSSP



Monitoring_QEHSSP_
Financing_Plan.xlsx

Annex 8: PIH Database for QEHSSSP project



QEHSSSP PIH
Training Database - w

Annex 9: PHU numbers in hob & spokes with CHWs



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Annex 10: Management Response



QEHSSP_MoH_NaME
A_Collaboration_Next

Annex 11: A table documenting some of the progress made using the Hubs and Spokes 5S model

MAJOR ACHIEVEMENTS RECORDED BY THE QEHSSSP PROJECT UNDER THE 5 Ss

KEY PROJECT UPDATE USING FIVE Ss (5s)	STATUS

STAFF	Recruited gap filling clinical and non-clinical staff for hubs and DHMTs: The QEHSSSP project has recruited 308 clinical and non-clinical staff (145 by IHPAU, 163 by PIH) in addition to the government staff maintained in the project health facilities.
	Conduct training for health workers: From 2023 to 2025, the project has trained 2,479 health workers. PIH has trained 2,362 health workers across the 5 project districts in IMNCI, EmONC, IOCG, Short- and Long-term family planning, IPC, MPDSR, and AYFS. Some participants have been trained in more than one discipline - 396 from Hubs, 1,487 from Spokes, 272 from district hospitals, DHMTs and other CHCs in the districts. 301 students are being trained as Physician Assistants through the SCS and 23 para veterinaries fully funded by the project and trained through MAFS (Njala University). The project has also developed various curricula at CoHMAS including dentistry, public health, medico surgical nursing, midwifery and pediatrics.
STUFF	Annual procurement and distribution of drugs, medical and lab equipment and reagents: The project procured and distributed drugs to all hub facilities in Kailahun, Bonthe, Tonkolili, Falaba and Western Area Rural Districts in since 2024 to date. The project has procured and equipped every facility with medical equipment ranging from delivery beds, ultrasound scans, hospital beds etc. The project has equipped laboratories with high end Bio-chemistry analyzers, hematology analyzers and other state-of-the-art laboratory equipment with reagents supplies routinely.
SPACE	Rehabilitation of 13 hubs: The project has completed the rehabilitation of Bandajuma Yawei and Beudu CHCs in Kailahun District with Goderich and Waterloo CHCs in the Western Area Rural District on-going over 90% complete. The procurement process for the remaining hubs is on-going, however, corrective maintenance and quick fixes are being done as and when needed.
SYSTEM	Health systems strengthening: The QEHSSSP project continues to strengthen health systems at sub project levels including; conduct of in-charges, FMCs, MDSR meetings; undertaking blood drives;

	decentralizing financing (petty cash to hubs and DHMTs); establish a GRM system, support CHWs data collection etc.
SOCIAL SUPPORT	Provide social support to project beneficiaries: The project has established GBV at sub-product level and has conducted community outreach for nutrition, continually provide therapeutic foods and provide livelihood support and supplies for GBV Survivors.

Annex 12: The expected pregnant women population for 2024 was used for 2021 to 2025

<i>Hubs</i>	<i>2021</i>	<i>2022</i>	<i>2023</i>	<i>2024</i>	<i>2025</i>
<i>Bandajuma CHC</i>	<i>147</i>	<i>127</i>	<i>168</i>	<i>158</i>	<i>247</i>
<i>Bendugu CHC</i>	<i>154</i>	<i>96</i>	<i>134</i>	<i>107</i>	<i>208</i>
<i>Buedu CHC</i>	<i>135</i>	<i>168</i>	<i>144</i>	<i>115</i>	<i>142</i>
<i>Falaba CHC</i>	<i>750</i>	<i>745</i>	<i>701</i>	<i>441</i>	<i>754</i>
<i>Goderich CHC</i>	<i>312</i>	<i>337</i>	<i>335</i>	<i>349</i>	<i>348</i>
<i>Hinistas CHC</i>	<i>878</i>	<i>616</i>	<i>981</i>	<i>1036</i>	<i>1352</i>
<i>Jojoima CHC</i>	<i>136</i>	<i>158</i>	<i>133</i>	<i>162</i>	<i>221</i>
<i>Kurubonla CHC</i>	<i>316</i>	<i>518</i>	<i>698</i>	<i>329</i>	<i>253</i>
<i>Masingbi CHC</i>	<i>318</i>	<i>294</i>	<i>343</i>	<i>362</i>	<i>326</i>
<i>Mattru UBC Hospital</i>	<i>221</i>	<i>249</i>	<i>344</i>	<i>307</i>	<i>382</i>
<i>Mongo Bendugu CHC</i>	<i>468</i>	<i>573</i>	<i>910</i>	<i>540</i>	<i>537</i>

<i>Moriba Town (Imperri) CHC</i>	<i>192</i>	<i>121</i>	<i>184</i>	<i>238</i>	<i>471</i>
<i>Tihun CHC</i>	<i>915</i>	<i>1168</i>	<i>1403</i>	<i>1423</i>	<i>2873</i>
<i>Waterloo CHC</i>	<i>178</i>	<i>195</i>	<i>382</i>	<i>390</i>	<i>477</i>

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