### BASIC INFORMATION

#### A. Basic Project Data

<table>
<thead>
<tr>
<th>Country</th>
<th>Project ID</th>
<th>Project Name</th>
<th>Parent Project ID (if any)</th>
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<tbody>
<tr>
<td>Liberia</td>
<td>P169641</td>
<td>Institutional Foundations to Improve Services For Health</td>
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<table>
<thead>
<tr>
<th>Region</th>
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<th>Estimated Board Date</th>
<th>Practice Area (Lead)</th>
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<td>AFRICA</td>
<td>06-Apr-2020</td>
<td>21-May-2020</td>
<td>Health, Nutrition &amp; Population</td>
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<tr>
<th>Financing Instrument</th>
<th>Borrower(s)</th>
<th>Implementing Agency</th>
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<tbody>
<tr>
<td>Investment Project Financing</td>
<td>Republic of Liberia</td>
<td>Ministry of Health</td>
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**Proposed Development Objective(s)**

To improve health service delivery to women, children and adolescents in Liberia.

**Components**

- Component 1: Improved service delivery
- Component 2: Institutional strengthening to address key binding constraints
- Component 3: Project Management

### PROJECT FINANCING DATA (US$, Millions)

#### SUMMARY

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Total Project Cost</td>
<td>54.00</td>
</tr>
<tr>
<td>Total Financing</td>
<td>54.00</td>
</tr>
<tr>
<td>of which IBRD/IDA</td>
<td>54.00</td>
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<tr>
<td>Financing Gap</td>
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#### DETAILS

**World Bank Group Financing**

| International Development Association (IDA) | 54.00 |
| IDA Credit                                  | 54.00 |
Environmental and Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)

B. Introduction and Context

Country Context

1. Liberia is a fragile state striving to overcome the legacy of two devastating civil wars, and the twin shocks of the Ebola Virus Disease (EVD) crisis (2014-2016) and the protracted slump in global commodity prices. The two civil wars between 1989-2003 caused widespread loss of life, suppressed economic activity, and destroyed vital infrastructure. Thereafter, Liberia experienced sustained economic growth, and its per capita Gross Domestic Product (GDP) grew by 6.2 percent on average per year between 2003 and 2013. However, the twin shocks brought Liberia’s renewed expansion to a halt. Between 2014-2016, the economy contracted at an average rate of 0.8 percent per year or 3.2 percent in per capita terms. The recovery from the twin shocks was brief and fragile, and the macroeconomic situation deteriorated markedly in 2018-2019. Following modest growth of 1.2 percent in 2018, the economy contracted by an estimated 2.3 percent in 2019, on the back of falling demand and output. Headline inflation reached 27 percent in 2019 from 23.4 percent in 2018, largely due to the currency depreciation (by 29.4 percent y/y) combined with supply-side constraints, the monetization of the fiscal deficit, and financing of the Central Bank of Liberia’s (CBL) large deficit. Domestic food prices increased by 35.9 percent as a result of a poor harvest.

2. Liberia’s fledgling economy, which has never fully recovered from the multiple shocks during 2014-2016, is now facing the COVID-19 outbreak. Under the baseline scenario, real GDP is projected to contract by 2.2 percent in 2020 due to the adverse effects of COVID-19 on output in various sectors amid falling global demand and travel disruptions. A sharp rebound is expected over the medium-term, supported by an improved performance of the non-mining sectors, underpinned by post-COVID-19 recovery and structural reforms designed to alleviate constraints on productivity growth and enhance economic diversification. Growth is projected to recover to 4.0 percent on average during 2021-22. Risks are tilted to downside: as COVID-19 spreads locally, further disruptions in economic activity would lead to a further contraction in 2020, followed by a modest recovery in 2021.

3. With Gross National Income (GNI) per capita at $600 in 2018, Liberia remains a low-income country and among the ten poorest countries in the world. More than half of Liberia’s 4.9 million people live in urban

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2 Liberia: Macro-Poverty Outlook, Spring Meetings 2020.
areas, and one quarter resides in the capital city, Monrovia. Adolescents and youth\(^3\) (10-24 years old) represent approximately one-third of the total population. According to the 2016 Household Income and Expenditure Survey (HIES), 40.9 percent of the population lives below the international poverty line of US$1.9/day in 2011 purchasing-power-parity (PPP) terms. Negative per capita GDP growth rates during 2017-2019 further increased the poverty incidence to an estimated 44.5 percent in 2019. The proportion of poor households living below the international poverty line of US$1.9/day (2011 PPP) is projected to increase further to 45.4 percent in 2020 in line with continued negative per capita income growth before marginally decreasing to 44.4 percent in 2022. While it is difficult to gauge the welfare impact of the COVID-19 pandemic precisely, households are expected to be affected negatively due to potential impact on employment, particularly the non-farm self-employed in urban areas, high prices of imported goods, restrictions on trade, and losses either in terms of the sale of productive assets or consumption of working capital as they try to cope.

4. Non-monetary poverty indicators in Liberia, including access to healthcare, education, and basic utility services are also low by regional and international standards, with especially acute rural-urban and gender disparities. For example, among wealthier households and households in urban areas, 48 percent of children between the ages of 6 and 11 years attend primary school, compared to just 26 percent of children from poorer households and households in rural areas. Significant urban-rural and gender disparities in poverty rates are largely driven by unequal access to land and other productive assets, infrastructure and public services, and markets for both goods and labor.

5. Women face severely limited economic opportunities and endure poor human development outcomes. Liberian women experience high rates of early pregnancy, school dropout, and child and maternal mortality, all of which are especially common among poor households. Female retention in school is low, with only 15 out of every 100 girls who begin primary school advancing to grade 10. Dropout rates during grades 10, 11, and 12 is a critical issue. In addition to poverty, other factors driving high dropout and low retention rates among females include a lack of support at school/home to continue with education, lack of school safety and limited, if any, gender-appropriate facilities (water and sanitation), food insecurity, and pregnancy and early marriage. Early marriage and childbearing, especially in rural areas, widen gender gaps in education, and poor households often focus their limited resources on educating boys. Early childbearing is associated with young women dropping out of school, with lasting negative impacts on their skills and economic empowerment.

6. Fragility is both a cause and consequence of poor human capital outcomes; the Human Capital Index (HCI) for Liberia is 0.32, ranking 153 of 157 countries. The HCI\(^4\) – a composite index based on measures of health, education, and nutrition – shows that the average Liberian child born today will only be 32

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\(^3\) World Health Organization (WHO) defines young people as individuals between ages 10 and 24. Adolescents represent the 10-19 years old age group and youth represent the 15-24 years old age group.

\(^4\) HCI is made up of five indicators and data for Liberia shows: the probability of survival to age five (93 out of 100 children born in Liberia survive to age 5); a child’s expected years of schooling (a child who starts school at age 4 can expect to complete 14.4 years of school by her 18th birthday (and 2.3 is the learning-adjusted years of school)), harmonized test scores as a measure of quality of learning (332 on a scale where 625 represents advanced attainment and 300 represents minimum attainment), adult survival rate (fraction of 15-year olds that will survive to age 60 -77%); and the proportion of children who are not stunted (68 out of 100 children, and therefore 32 out of 100 children are at risk of cognitive and physical limitations that can last a lifetime).
percent as productive when they grow up as they could be if they enjoyed complete education and full health.\(^5\) Adequate nutrition, particularly in the first five years of a child’s life, is vital to physical, social, and cognitive development; and to a child’s readiness to learn and is linked to better educational and economic outcomes. According to the most recent Demographic and Health Survey (2013), a third of Liberian children under-5 years are stunted (32 percent), and while stunting declined between 2007 (39 percent) and 2013 (32 percent)\(^6\), Liberia still reports the sixth-highest stunting rate in West Africa\(^7\), which pose cognitive and physical limitations that can last a lifetime. This is further compounded by poor learning outcomes in schools. For example, a child in Liberia can expect to complete 4.4 years of pre-primary, primary and secondary school by age 18. However, when years of schooling are adjusted for quality learning, this is only equivalent to 2.3 years\(^8\).

### Sectoral and Institutional Context

1. **Liberia has some of the worst maternal and child health outcomes in the region and globally (Table 1).** Liberia’s maternal mortality rate at 1,072 deaths for every 100,000 live births (i.e., 1 death for every 93 women) is among the highest in the world. The neonatal mortality rate (deaths within the first 28 days of life) is also high, at 37 per 1,000 live births, and accounts for a third (35 percent) of all under-5 deaths\(^9\). Of Liberia’s 15 counties, Montserrado county, which is home to a large proportion of the population of the country and the capital city Monrovia, reports the highest number of maternal and neonatal deaths (details described in Technical Analysis Section IV A). Deaths in mothers and neonates are largely driven by preventable and treatable complications. These include hemorrhage (25 percent), hypertension (16 percent), unsafe abortion (10 percent), and sepsis (10 percent) in mothers, and birth asphyxia and sepsis in neonates, all of which point to the critical gap in quality care during the antenatal, perinatal and postpartum period. Outside the neonatal period, children in Liberia mainly die from infectious diseases, including pneumonia (14 percent), malaria (13 percent), and diarrhea (9 percent)\(^10\).

<table>
<thead>
<tr>
<th>Selected indicators</th>
<th>Liberia</th>
<th>Guinea</th>
<th>Sierra Leone</th>
<th>Ghana</th>
<th>SSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total fertility rate (births per women (yr: 2017))</td>
<td>4.4</td>
<td>4.7</td>
<td>4.3</td>
<td>3.9</td>
<td>4.8</td>
</tr>
<tr>
<td>Child mortality rate (1,000 live births)</td>
<td>44</td>
<td>42</td>
<td>120</td>
<td>62</td>
<td>77.5</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>54</td>
<td>61</td>
<td>87</td>
<td>43</td>
<td>52.7</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>1,072</td>
<td>650</td>
<td>1,100</td>
<td>380</td>
<td>534</td>
</tr>
<tr>
<td>Births attended by skilled health personnel (percentage)</td>
<td>61</td>
<td>45</td>
<td>60</td>
<td>68</td>
<td>57.8</td>
</tr>
<tr>
<td>Adolescent fertility rate (2017) births per 1000 women age 15-19</td>
<td>136.6</td>
<td>135.3</td>
<td>112.8</td>
<td>66.6</td>
<td>102.8</td>
</tr>
</tbody>
</table>


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5 The HCI for Africa Region is 0.40 (lowest amongst all Regions), and the target for 2023 (aligned with the Sustainable Development Goals and World Bank Group’s Africa Strategy) is to increase to 0.45.

6 Liberia DHS report 2013.


9 Source: Republic of Liberia: Investment case for reproductive, maternal, new-born, child and adolescent health, 2016-2020

10 Idem.
8. **Adolescent health and fertility remains an area of serious concern.** A third (31 percent) of teenagers in Liberia begin childbearing by age 19, and maternal deaths disproportionately affect adolescent girls. Liberian adolescents rank as having the fourth highest fertility rate (129 births per 1,000 women age 15-19 years) in West African countries, after Niger, Mali, and Guinea (194 births, 171 births, and 137 births per 1,000 women age 15-19 years respectively). Moreover, compared to its neighboring countries – Sierra Leone and Guinea – Liberia experienced the lowest rate of decline in the adolescent fertility rate between 2000 and 2016. Adolescent fertility contributes to total fertility and limits the ability of young women to accumulate human capital. Fertility is both a driver of Human Capital outcomes and requires added efforts to improve Human Capital at risk. Regional experience shows that rapid progress is possible – Senegal, Malawi, Uganda, and Rwanda reduced adolescent fertility rate by more than 6 percent a year.

Multisectoral interventions, including focused behavior change, will be key drivers. Improving adolescent sexual and reproductive health outcomes is a priority area of investment for the Government of Liberia (GOL) to create the conditions for demographic transition and human capital accumulation for women and girls.

9. **Female retention in schools is very low, particularly at the high school level, and schools are generally not a safe environment for girls.** A recent study found that 32 percent of girls who had dropped out of school reported feeling unsafe in school, and 30 percent of female students were forced to have sex against their will. Girls and young women are victims of sexual exploitation and abuse, often being forced to engage in transactional sex to have their basic needs met, including the cost of transportation to school and money to cover school fees. Moreover, schools do not sufficiently address sexual and reproductive health for adolescents. Collaboration between the Health and Education sector is critical to keeping girls, and particularly adolescents, in school in a safe and informed environment.

10. **Health outcomes and access to health services suffer wide socio-economic and geographic disparities.** The poorest are twice as likely to encounter problems in accessing reproductive health care compared to the richest. The gap in antenatal coverage is seven percentage points higher for the richest than the poorest; this gap widens to 46 percentage points for coverage of skilled birth deliveries. Similarly, children aged 12-23 months from the richest population are 1.6 times more likely to receive full vaccination compared to those from the poorest. Furthermore, children under five from the richest population are 1.2 times as likely to have febrile treatment sought for them from a healthcare provider compared to those from the poorest population. Consequently, outcomes are worse for the poorest. For example, children under five from the poorest population are 1.7 times more likely to be stunted, and twice as likely to be underweight compared to those from the richest. In 2016, the share of women accessing postnatal care ranged from 50 percent in Bong County to 17 percent in Margibi County. Similar variations were observed across indicators of child healthcare coverage, and full-immunization rates for children below

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11 Idem.
12 WDI 2018
14 World Bank Study – Education sector
15 IDA Project Appraisal Document for Improving Results in Secondary Education Project, June 2019.; Primary and junior secondary school are tuition-free; however, enrollment fees are required at the senior secondary level.
16 Based on analysis of data from 2017 World Development Indicators (WDI) dataset
17 All other data referenced in this paragraph were based on analysis of the 2013 LDHS
the age of one ranged from 94.5 percent in Bong County to just 34 percent in River Gee.

HEALTH SYSTEM CHALLENGES

11. **The protracted civil wars and the EVD outbreak severely eroded Liberia’s institutions and organizational capacity.** The health sector was particularly affected as it lost an invaluable mass of its skilled human resource and institutional asset base. At the same time, the capacity and organizational abilities of institutions essential for enabling an effective and efficient health system to function were severely depleted. This weak institutional base is reflected in an inadequate health workforce (in terms of inadequate numbers, limited skill-mix and distribution, and necessary technical skills to provide quality health care), with no clearly defined career path or incentives to work in the system, and with little accountability and transparency. Moreover, the dysfunctional management and organizational system hinder the availability of timely and affordable drugs and services for the sick and needy.

12. **Liberia made significant progress in health service delivery after the civil wars, and until 2013; however, the EBV outbreak (2014-16) reversed some of the previous gains and constrained the health system’s functionality.** Between 1986 and 2013, the country’s under-five and infant mortality rates declined from 220 to 94 deaths per 1,000 live births and 144 to 54 deaths per 1,000 live births, respectively. Moreover, health and service-delivery indicators improved between 2000 and 2013. Measles immunization coverage increased from 52 to 74.2 percent; the prevalence of stunting among children under five years old declined from 39 percent in 2007 to 32 percent in 2013, and; life expectancy at birth increased from 52 to 61 years. The EVD crisis reversed some of these achievements: deliveries by skilled birth attendants fell by 7 percent; fourth antenatal care (ANC) visits dropped by 8 percent, measles coverage rate declined by 21 percent, and health-facility utilization rates plummeted by 40 percent. Liberia also lost a staggering 10 percent of its doctors and 8 percent of its nurses and midwives to the EVD—a 2015 study estimated that the deaths of these workers potentially increased the maternal mortality rate by 111 percent relative to the pre-EVD baseline.

13. **Significant gaps in the quality of care contribute to the persistently high levels of maternal and neonatal mortality.** A review of maternal and neonatal death audit reports indicate significant gaps in the available quality of Emergency Obstetric and Neonatal Care (EmONC) – both at hospitals (meant to provide cesarean sections and neonatal intensive care) and primary level facilities (meant to manage uncomplicated labor and routine care of the newborn). The quality gaps in service provision cover the full range, including (i) a lack of reliable and consistent availability of power supply and water; (ii) skilled and committed human resources to provide quality antenatal, intrapartum and postnatal care; (iii) access to 24*7 care; (iv) essential life-saving commodities – oxygen, blood, oxytocin, magnesium sulfate, and intravenous antibiotics; (v) poor use of data for decision making; and (vi) lack of accountability amongst service providers.

14. **While funding to the health sector has increased in recent years, it remains insufficient to provide basic health services to the population and make sustained progress on health outcomes; and this is exacerbated by inefficiencies resulting from poor accountability and transparency.** The GOL has

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18 Source: Republic of Liberia: Investment case for reproductive, maternal, new-born, child and adolescent health, 2016-2020
prioritized the health sector over time: General Government Health Expenditure (GGHE) as a percentage of general government expenditure increased from 7 percent in 2000 to 12 percent in 2014, before reaching 13.6 percent for the 2017/18 fiscal year. The health sector’s appropriation in the FY 2019/2020 budget is 14.16 percent of the total national budget. Given the relatively small size of the total government budget, the increase of the GGHE is not enough to respond to the significant needs in the health sector. Almost three-fourths of the total budget expenditure in the health sector is accounted for within the wage bill. Over 40 percent of compensation payments are paid in the form of discretionary allowances, creating both inequity and inefficiency. Financing and the proportion of the total quantum of annual financing (allocated and released by the GOL) is insufficient to meet the basic health needs of the population. Consequently, the country’s per capita health expenditure remains low at US$72 (current US dollars), below the US$86 threshold necessary to provide a basic package of health services. The health sector systematically begins with an annual shortfall of required essential drugs and medical supplies, and even the scarce resources allocated are not efficiently used, with a significant lack of accountability in the system. The most impoverished bear the brunt: 15 percent of poor households encounter catastrophic health expenditures compared to only 8 percent among the rich. Outpatient services and over-the-counter payment for drugs are the main drivers of out of pocket (OOP) spending.

15. **The ongoing COVID-19 pandemic could have a detrimental impact on the already fragile health sector.** As of March 17, 2020, Liberia has three confirmed cases of COVID-19, and 434 contacts, including 40 health care workers, have been documented; 262 (60.4 percent) contacts have completed 14 days of quarantine. Considering the contextual and health system challenges in Liberia, in the absence of a rapid, effective, and sustained response, a COVID-19 outbreak could once again have a devastating impact on the fragile health system, health outcomes, and the broader Liberian economy. In response to this, the Bank has already mobilized support from the ongoing Regional Disease Surveillance Systems Enhancement Program (REDISSE) II project (P159040); and is also in the final stages of providing additional financing through a new project to complement this financing (Liberia COVID-19 Emergency Response Project; P173812). The new Liberia COVID-19 Emergency Response Project will focus on supporting the GOL’s National response to the current COVID-19 pandemic, while REDISSE II continues to address issues related to sustainability, and One health.

**NATIONAL POLICY RESPONSE**

16. **The Government of Liberia, in partnership with Development Partners, launched a coordinated response to challenges affecting Reproductive, Maternal, Child, and Adolescent Health (RMNCAH).** To address some of the key lagging health outcomes in the country, the GOL prepared and endorsed the

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20 Global Health Expenditures Database from WHO
21 MOH 2017
22 Estimated annual cost of essential package of drugs and supplies is US$ 22 million – of this US$ 11 million is provided (mainly in kind) by donors. The remaining US$ 11 million budgetary request made by MOH to MFPD, since the last 2 years only about US$ 4 million has been allocated, of which only US$ 640,000 was released to MOH in FY19.
24 2014 household survey. Catastrophic health expenditures are defined as 10% of total household consumptions.
25 Payment of outpatient services mostly apply to public facilities per the 2014 household survey. 72% of households went to a public health provider while 18% visited a private for-profit provider.
RMNCAH Investment case (IC) (2016-2020). Implementation of the IC is funded by the GOL and development partners (DPs), including the World Bank Group (WBG)/Global Financing Facility (GFF) Trust Fund, USAID, Global Fund, UNICEF, WHO, UNFPA, Government of Japan, GAVI, BMZ, and Last Mile Health. The IC accelerates strategies to improve essential health services nationally, prioritizing six out of fifteen counties, which, in 2015-16, had comparatively worse RMNCAH indicators and fewer resources. The six priority areas are: (i) quality emergency obstetric and neonatal care including ANC and postnatal care (PNC) and child health; (ii) strengthening the civil registration and vital statistics (CRVS) system; (iii) adolescent health interventions to prevent pregnancies at school level, mortality and morbidity during antenatal, childbirth, and postpartum periods, unsafe abortion, early and unintended pregnancy and sexually transmitted infections, and gender-based violence; (iv) emergency preparedness, surveillance and response, especially maternal and neonatal death surveillance and response (MNDSR); (v) sustainable community engagement; and (vi) leadership, governance and management at all levels. While progress has been made in some areas, more is needed to address the high levels of maternal and newborn deaths, as well as health needs for adolescents. The joint development of the next IC, with the government in the lead, is an opportunity to broaden the scope (geographic, health system, and health financing issues) within the available resources. The timing of the next IC aligns well with the next funding cycle of main financiers showing interest to further align, including GFATM, USAID, and the WBG IDA (with a possible GFF TF second-round of financing).

17. Additional financing by the GFF Trust Fund to the ongoing IDA Health Systems Strengthening Project (P128909) is fully aligned with Liberia’s RMNCAH IC. Performance-Based Financing (PBF), supported by the GFF, has now been rolled out to eight hospitals and three counties. Counties and hospitals are paid on results linked to improving coverage and quality of RMNCAH services. This results-based approach helps the country move towards strategic purchasing as part of the government’s plan for Universal Health Coverage (UHC). A Technical Assistance agency has also been put in place to build the capacity of County Health Teams (CHTs) to deliver on these results. The payment of the agency is linked to increased competencies and skills of the CHTs. Improving community-level services with support to the Community Health Assistance (CHA) program has also been critical to improved access and utilization of services. The GFF also adds value by strengthening existing mechanisms for coordination between government, financiers, and other non-governmental stakeholders, including through improving financial resource

26 The GFF is a broad partnership that supports countries to get on a trajectory to achieve the Sustainable Development Goals (SDGs) by strengthening dialogue among key stakeholders under the leadership of governments. It facilitates the identification of a clear set of priority results that all partners commit their resources to achieving; getting more results from existing resources and increasing the total volume of financing from domestic government resources, financing from IDA and IBRD, aligned external financing and private sector resources; and strengthens systems to track progress, learn, and course-correct. This approach is guided by two key principles: country ownership and equity. The GFF is driven at the country level by a ‘country platform’: a forum or committee that brings together, under government leadership, the broad set of partners involved in improving the health outcomes of women, children, and adolescents, including different parts of the government, civil society, the private sector, and DPs. A multi-donor trust fund—the GFF trust fund—has been established at the World Bank Group to be a catalyst for this process.

27 Six priority counties include: Gbarpolu, Grand Bassa, Grand Kru, Rivercess, Rivergee and Sinoe county

28 Counties include:
mapping and tracking, and improving data analysis and use for decision making to prioritize and course-correct during implementation. The GFF provides implementation support for the IC through technical assistance on health financing, monitoring and evaluation, and technical implementation. Moreover, a Liberia-based Liaison Officer supports the Government’s Investment Case Implementation. With a portion of the available financing undisbursed, the GoL plans to continue these activities through an extension for one year after May 31, 2020.

18. There have been several critical achievements during the implementation of Liberia’s RMNCAH IC, which represent important steps towards improved RMNCAH services in Liberia. First, the Ministry of Health (MOH) has started to annually map the IC resources contributed by partners and the Government. PBF is now implemented in nine counties (six supported by USAID and three by the GFF/WBG) as well as eight hospitals supported by the GFF/WBG. PBF covers four of the country’s six RMNCAH priority counties. The country now implements MNDSR, a major step in reporting and understanding maternal and newborn mortality. Trainings and mentorships on EmONC have taken place to improve maternal and newborn care, with more than 900 health workers trained. Revisions to the Country’s Public Health Law are underway to improve access to adolescent sexual and reproductive health services (ASRH). Community health workers are an important avenue to reach people in remote rural areas and engage with hard to access communities. Liberia’s CHA program supports community health workers in rural areas more than five kilometers from facilities. Support for CHAs is coordinated between partners with common guidelines, indicators, and a training curriculum.

19. There have been challenges in the implementation of the IC. They include: (i) severe shortages of essential medicines at facilities due to inadequate budget allocation and supply chain challenges; (ii) gaps in primary and secondary care due to reductions in government allocations to facilities and counties, and (iii) inconsistencies in the regularity of county platform meetings as well as the use of data to track the IC progress. In addition, there are substantial disparities in the coverage of critical maternal and newborn health services across the country. For example, the rate of skilled delivery varies from 31 percent in Montserrado County to 99 percent in Nimba County) and PNC for women range from 14 to 95 percent between the same two counties, at the extreme ends of the spectrum. These challenges contribute to the country’s high maternal and neonatal mortality rates and underscores the need to build on the IC achievements by focusing on RMNCAH results to improve outcomes.

20. Plans and programs are in place, but low financial investment and binding constraints often hinder the attainment of desired results. In addition to the RMNCAH IC, during the last few years, many elaborate plans have been prepared and agreed to improve Liberia’s health system and its corresponding health indicators. These plans, however, have usually not been implemented as planned; and where implemented, the focus has not been sufficiently technical to address the challenge. Moreover, there is limited orientation towards governance, institutional, and organizational reforms for sustainable impact. There are a range of underlying critical challenges that Liberia faces, and these translate into some of the key binding constraints to implementation. Key areas include: (i) human resource management; (ii) availability of inputs, and drug procurement and supply chain management systems; (iii) public financial management (PFM) and efficiency; (iv) bringing citizen’s voices into health governance; and (v) improving

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29 List counties where PBF is implemented?
transparency and accountability at all levels of the system. Moreover, digitization and technology provide opportunities that have not been exploited to the fullest in the country\textsuperscript{30}. To contribute towards improving health outcomes for women, children, and adolescents in Liberia, this project will address these key binding constraints\textsuperscript{31}. International experience in similar country contexts show that governance and institutional issues are often most effectively addressed by financing results instead of inputs. Creating a framework of incentives to support the long-term implementation of strategic institutional reforms will be critical to creating sustainable change in Liberia.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)
To improve health service delivery to women, children and adolescents in Liberia.

Key Results
The following indicators will be used to monitor progress towards the achievement of the PDO:

(i) Redemption Hospital Phase 1 and 2 fully completed and operational to provide comprehensive services to women, children and adolescents;
(ii) Institutional deliveries attended by skilled birth attendants (medical doctors, physician assistants, registered nurses, registered/certified midwife) (percentage);
(iii) Pregnant women with four or more ANC visits (percentage);
(iv) Proportion of new users of modern contraception who are adolescents (10-19 years).

D. Project Description

Component 1. Improved service delivery
This component would be financed using the traditional IPF approach and include the following subcomponents:

21. \textbf{Subcomponent 1.1. Operationalizing new Redemption Hospital Phases 1 and 2} This subcomponent will finance the design, construction and supervision of Phase 2, and the procurement and installation of equipment for both Phases 1 and 2 of the new Redemption Hospital. The procurement of equipment will be conducted in stages, based on the respective construction completion timelines for Phases 1 and 2. Construction of Phase 1 is ongoing, financed by the ongoing Ebola Emergency

\textsuperscript{30} Technology and innovation offer countless opportunities to address supply and demand side constraints to Human Capital acceleration.

\textsuperscript{31} Key binding constraints to implementing health sector programs and plans are fourfold. Stakeholder consultation, analysis, and discussions have identified an exhaustive list of constraints, which can be categorized into four broad areas: (i) resource availability and management: drugs, people, finance, assets, and information; (ii) organizational structure and systems: organizational, managerial, individual accountability, lack of enforcement and lack of compliance with regulation, decentralization, and devolution (the structure of power); (iii) managerial: information for evidence-based decision-making; (iv) institutional: civil service structure, and political economy incentives. Further inquiry and deliberations point to the urgent need to address the underlying constraints in at least the areas of human resources, supply chain management, and information for evidence-based decision-making. Implementation of all existing plans and programs would significantly improve if practical reforms and solutions are supported in these key areas.
Response Project (P152359). While construction is scheduled to be completed by March 2021, construction progress to date indicates that there may be a delay of a few months. The Government will inform the WBG by mid-2020 at the latest if an extension is required. Preliminary design and cost estimates were done for Phase 2 at the conceptualization stage, and a design and supervision consultant firm will need to be contracted to detail and finalize these elements.

- **Subcomponent 1.2. Enhancing human resource skills**
  22. To ensure the delivery of quality health services at all levels, qualified and skilled personnel are required. Since 2013, the WBG – through several HNP operations – has directed an estimated US$13.5 million towards the training of Liberian health personnel. This included support to re-establish undergraduate medical education at A.M.Dogliotti. Medical College and initiate post-graduate training at the Liberia College of Physicians and Surgeons (LCPS). Forty-five medical doctors have graduated, with specialties in internal medicine (11), general surgery (12), pediatrics (9), and Obstetrics & Gynecology (13). Under this sub-component, the project will cover costs related to the training of undergraduate and post-graduate health personnel at the A.M.D Medical College and LCPS.\(^{32}\)

- **Subcomponent 1.3. Scaling-up the successes of PBF**
  23. Under this sub-component, the proposed project will support costs related to the provision of maternal, adolescent, and child services through PBF at select primary health care centers and hospitals. While the WBG and USAID both currently support PBF in Liberia, each institution implements its own model of PBF. The GOL has requested that USAID and the WBG design an integrated model, which will be scale-up to the rest of the country. To inform the design of the new PBF model, the GFF is financing implementation research on Liberia’s experience with PBF (estimated date of completion: April 2020), and an impact evaluation of the current PBF models, financed by the Health Results Innovation Trust Fund, is being conducted (end line study to commence in June 2020). Once the new PBF model is developed, the proposed project will support costs related to the implementation of the model, including (i) PBF subsidies to primary health care facilities and hospitals; (ii) verification of results by independent verification agencies/modalities; (iii) technical assistance to support the design and implementation of the new model, and (iv) training, monitoring and evaluation (M&E), and other operational costs.

- **Subcomponent 1.4. Support to the national Community Health Assistant (CHA) Program**
  24. This subcomponent will finance incentives provided to CHAs in selected counties. The project will incentivize CHAs based on their reporting on pre-agreed indicators that aim to improve the quality of ANC, PNC, and follow-up in the community, including the link between the community and health facilities.

- **Subcomponent 1.5. Support for community and school health interventions to improve access to**

\(^{32}\) The GOL has requested financing for five years (2020-2025) to address a financing gap of US$11.5 Million to support (i) the undergraduate program, (ii) 48 post-graduates in four specialities (internal medicine, surgery, paediatrics and obstetrics & gynaecology), and (iii) 19 post-graduates in other specialities.

\(^{33}\) The ongoing Health System Strengthening Project (P128909) supports PBF in 3 counties and eight hospitals, and USAID supports PBF in six counties.
adolescent health care

25. This subcomponent will finance select evidence-based interventions that support the longer-term objective of contributing to the reduction of teenage pregnancies and maternal mortality. Specifically, the project will support costs related to the contracting of an experienced non-governmental organization (NGO), to implement activities that enhance community engagement and behavior change towards teenage pregnancy and appropriate health care. At the school level, this subcomponent will finance costs related to joint activities by the Ministry of Health (MOH) and the Ministry of Education (MOE) to improve sexual and reproductive health learning. The project will also support the MOH to provide inputs to, and monitor, female health counselors in high schools recruited through the WBG’s Education project. These female health counselors aim to enhance the sexual and reproductive health knowledge and behavior of adolescents in school.

- **Subcomponent 1.6. Improve availability of essential medicines and RMNCAH products**

26. Access to quality pharmaceuticals is a significant constraint to improving RMNCAH outcomes in Liberia. This subcomponent will cover costs related to the procurement of selected essential medicines and supplies, required to save lives of mothers and neonates (oxytocin, misoprostol, magnesium sulfate, intravenous antibiotics for mothers and newborn, intravenous fluids, oxygen, blood, etc.).

Component 2. Institutional strengthening to address key binding constraints

This component would be financed using IPF with DLIs and include the following subcomponents. The annual Disbursement-Linked Results (DLRs), except for the “Year Zero” DLRs, are based on annual accomplishments, and hence will be time-bound to that year and not scalable. Only the DLRs for Year Zero can be carried over to Year 1. If they are not achieved by the end of Year 1, then a detailed discussion will be held to consider the use of ILIs (output-based), and/or to change/restructuring the DLRs.

- **Subcomponent 2.1. Enhanced and reliable data availability and evidence-based decision making**

27. In Liberia, the availability of reliable and timely data, and its use for evidence-based decision making is unsystematic and weak, contributing to ineffective service delivery. Moreover, there is limited accountability in data reporting and where data exists, it is often partial or outdated. This DLI-financed subcomponent will support the development of standards and procedures that ensure the availability of reliable and timely data at all levels and across all functions of the health system. It aims to incentivize: (i) effective planning and management; (ii) the use of facility-level data for implementation, and decision-making at a more senior level, and (iii) mechanisms for data sharing with communities. Improved systems will allow for regular data capture and monitoring of disaggregated data, which can be consolidated and used for planning and decision making, including equitable resource allocations.

- **Subcomponent 2.2. Effective supply chain management**

34 Proposed community based adolescent activities in the project would include some activities that SWEDD has successfully implemented, e.g., promoting social and behavioral changes, empowering women and girls to increase demand for RMNCHN services; and better awareness of populations to foster political commitment and capacity for policy making and advocacy.
28. The MOH does not have a robust logistics and supply chain management system, which makes it difficult to assess, manage, and monitor drug availability at counties and facilities. This subcomponent will support activities that enhance coordination between DPs to strengthen medical supply management, including family planning and reproductive health commodities. Specifically, this subcomponent will finance activities that strengthen procurement management and forecasting, improves inventory management and logistics, warehousing - accessibility, security, stock management, and information systems. Enabling proper planning, budgeting, execution of procurement and quality assurance, and improved efficiency in the distribution and reporting will lead to reductions in drug stock-outs and enable the timely availability of drugs at health facilities, and to all populations. The major bottleneck, however, of an overall limited annual drug budget made available to MOH, will be addressed through continuous policy discussions and maximizing efficiencies.

- **Subcomponent 2.3. Improved human resource management**

29. Effective strategies are needed to encourage and incentivize the availability of appropriate staffing, especially in remote areas, to ensure quality of care at the point of service delivery. This subcomponent will support costs related to the MOH’s development and implementation of an effective human resource strategy and performance management system. This would include addressing critical inefficiencies in the current system that impacts on the effectiveness of service delivery and the motivation and accountability of staff – e.g. lack of clear job descriptions, non-existent career paths, no transparency in selection, postings and transfers, urban-rural disparities, untimely payment of salaries, disparities in salaries, and incentives and motivation. Enabling the creation and implementation of effective strategies for human resource management will encourage equitable distribution and retention of motivated personnel and health support staff at different levels of the organization – MOH, counties, hospitals, and primary level – support better service delivery across the health system in Liberia.

- **Subcomponent 2.4. Support for school-based interventions to improve adolescent health (with a focus on girls)**

30. This subcomponent will support the MOH to provide inputs to the education sector and to monitor female health counselors in high schools recruited through the WBG’s Education project. These female health counselors aim to enhance the sexual and reproductive health knowledge and behavior of adolescents in school, and support girls who drop-out because of pregnancy.

- **Subcomponent 2.5. Strengthened citizen engagement**

31. This sub-component will support activities to strengthen community and citizen engagement by improving their access to information, and capturing their voice and feedback, which will improve the responsiveness of the Government in addressing constraints to access. Improved accountability will encourage service providers to “supply” the services for which they are responsible.

**Component 3. Project Management**

- **Subcomponent 3.1: Project coordination** This subcomponent will administrative support to the Project Implementation Unit (PIU), including contractual specialists, administrative supplies, and
capacity building.

- **Subcomponent 3.2: Monitoring-Evaluation (monitoring, supervision, and support)**

32. The general underlying principle is to ensure alignment of the M&E process developed for the project with the national M&E system. This subcomponent will support costs related to the M&E of project activities, capacity building, technical assistance to formulate an M&E plan for the project, and hiring of the independent verification agency/organization for DLI verification.

**Component 4. Contingent Emergency Response Component**

33. This component is included in accordance paragraphs 12 and 13 of the World Bank IPF Policy, contingent emergency response through the provision of immediate response to an Eligible Crisis or Emergency, as needed. There is a moderate to high probability that during the life of the project the country could experience another epidemic or outbreak of public health importance or other health emergency with the potential to cause a major adverse economic and/or social impact on the health sector. This would result in a request to the Bank to support mitigation, response, and recovery activities in the county(s) affected by such an emergency. The CERC will allow the Government to request from the World Bank rapid reallocation of project funds to respond promptly and effectively to an emergency or crisis. An operations manual for this component will be developed if/when needed.

### Legal Operational Policies

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<thead>
<tr>
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<tr>
<td>Projects on International Waterways OP 7.50</td>
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<tr>
<td>Projects in Disputed Areas OP 7.60</td>
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### Summary of Assessment of Environmental and Social Risks and Impacts

In view of the nature of the proposed project activities, the Environmental and Social Standard (ESS) 1 does apply. The initial assessment of the project components anticipates potential risks and impacts related to (i) Non-discrimination and inclusion of vulnerable and disadvantaged groups—this will be particularly relevant to the component that supports adolescent reproductive health and teenage pregnancy, given the extensive stakeholder engagement and communication/messaging on social norms and behavior change. (ii) Labor and working conditions (ESS2) of project direct workers, including staffs of project implementing agency and contracted workers under project component on the human resource management. This will be assessed and analyzed during project preparation and a draft Labor Management Procedure shall be prepared as part of the ESMF and disclosed prior to the appraisal. (iii) Community health and safety (ESS4) under supply chain management component – disposal and management of medical waste, lack of awareness among people, lack of medical waste disposal sites, proper waste management procedure for unused, expired and damaged drugs, may pose risks and threats for community health and safety. (iv) Given the focus on adolescent reproductive health, teenage pregnancy and fertility, the contextual and project-level GBV risks would need to be assessed in line with the emerging World Bank GBV risk assessment procedure. The GBV risk assessment and action plan will be completed and disclosed prior to the appraisal as part of the ESMF. (v) The proposed activities under the component that supports enhanced data collection and availability may pose risk of data privacy and protection.
The security issues related to data protection will be assessed further during project preparation. (vi) The aspects of behavioral change, introducing new practices and system under the project may pose risks and threats for intangible cultural traits and traditions (ESS8). These risks and impacts will further be assessed and reflected in the ESMF, SEP and ESCP as appropriate. The draft ESMF, SEP and ESCP will be prepared by the government and, after review and cleared by the bank, the safeguards instruments shall disclosed prior to the appraisal.

E. Implementation

Institutional and Implementation Arrangements

**Ministry of Health** - The Ministry of Health (MOH) will serve as the executing Ministry of the Government for the project. It will make a full utilization of all its departments and units relevant to the Project.

**Project Implementation Unit (PIU)** - The PIU will be responsible for overall project planning, oversight, coordination and management. In conduct of its responsibilities, the PIU serves as the principal liaison with the World Bank.

**Project Financial Management Unit** - The Project Financial Management Unit (PFMU) of the Ministry of Finance and Development Planning (MFDP) shall be responsible for financial management aspects of the project in accordance with the Financing Agreement, PFM law, accounting and auditing requirements of the Financial Procedure Manual and the Project Implementation Manual.

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<tbody>
<tr>
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<tr>
<td>Approved By</td>
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<tr>
<td>Environmental and Social Standards Advisor:</td>
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<tr>
<td>Practice Manager/Manager:</td>
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