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Report No: PAD4706

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL CREDIT
IN THE AMOUNT OF US$20.00 MILLION

AND A

PROPOSED ADDITIONAL GRANT
IN THE AMOUNT OF US$11.00 MILION
FROM THE GLOBAL FINANCING FACILITY

TO THE

REPUBLIC OF LIBERIA

FOR THE

LIBERIA INSTITUTIONAL FOUNDATIONS TO IMPROVE SERVICES FOR HEALTH PROJECT

September 7, 2022

Health, Nutrition and Population Global Practice
Western and Central Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective July 31, 2022)

Currency Unit =	Liberian dollar (LRD)
LRD 153.25 =	US$1.00

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Ousmane Diagana
Country Director:	Pierre Frank Laporte
Regional Director:	Dena Ringold
Practice Manager:	Magnus Lindelow
Task Team Leaders:	Collins Chansa, Kazumi Inden

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
BCG	Bacille Calmette-Guerin
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHA	Community Health Assistant
CPF	Country Partnership Framework
CRVS	Civil Registration and Vital Statistics
CSO	Civil Society Organization
DA	Designated Account
DALYs	Disability Adjusted Life Years
DHIS-2	District Health Information System 2
DLI	Disbursement-Linked Indicator
EERP	Ebola Emergency Response Project
ESCP	Environmental and Social Commitment Plan
ESMP	Environmental and Social Management Plan
ESS	Environmental and Social Standards
EVD	Ebola Virus Disease
FM	Financial Management
GAC	General Auditing Commission
GBV	Gender-based Violence
GDP	Gross Domestic Product
GFF	Global Financing Facility
GoL	Government of Liberia
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HCWMP	Healthcare Waste Management Plan
HFDC	Health Facility Development Committee
IC	Investment Case
IDA	International Development Association
IFISH	Institutional Foundations to Improve Services for Health Project
IFR	Interim Financial Report
IMCI	Integrated Management of Childhood Illnesses
ISR	Implementation Status and Results Reports
MoH	Ministry of Health
MPDSR	Maternal and Perinatal Death Surveillance and Response
NDC	Nationally Determined Contribution
NHCWMP	National Healthcare Waste Management Plan
NVA	National Verification Agency
PBC	Performance-Based Condition
PBF	Performance-Based Financing
PDO	Project Development Objective
PFMU	Project Financial Management Unit
PIM	Project Implementation Manual
PIU	Project Implementation Unit
PPSD	Project Procurement Strategy for Development

RMNCAH-N	Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
SDG	Sustainable Development Goals
SEA/SH	Sexual Exploitation and Abuse and Sexual Harassment
SEP	Stakeholder Engagement Plan
STEP	Systematic Tracking of Exchanges in Procurement
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
US$/USD	United States Dollar
USAID	United States Agency for International Development

Republic of Liberia
Additional Financing for the Institutional Foundations to Improve Services for Health Project

TABLE OF CONTENTS

BASIC INFORMATION – PARENT (Institutional Foundations to Improve Services For Health - P169641)

Country	Product Line	Team Leader(s)		
Liberia	IBRD/IDA	Collins Chansa		
Project ID	Financing Instrument	Resp CC	Req CC	Practice Area (Lead)
P169641	Investment Project Financing	HAWH3 (9322)	AWCW1 (6547)	Health, Nutrition & Population

Implementing Agency: Ministry of Health

Is this a regionally tagged project?
No

Bank/IFC Collaboration

No

Approval Date	Closing Date	Expected Guarantee Expiration Date	Environmental and Social Risk Classification
21-May-2020	31-Aug-2026		Moderate

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach [MPA]	[ ] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[✓] Fragile State(s)
[✓] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a Non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made disaster
[ ] Alternate Procurement Arrangements (APA)	[ ] Hands-on Expanded Implementation Support (HEIS)

Development Objective(s)

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

Ratings (from Parent ISR)

	Implementation			Latest ISR
	21-Sep-2020	04-Jun-2021	21-Jan-2022	28-Jul-2022
Progress towards achievement of PDO	S	S	S	S
Overall Implementation Progress (IP)	S	S	MS	MS
Overall ESS Performance	MS	MS	MS	MS
Overall Risk	S	S	S	S
Financial Management	S	S	S	S
Project Management	S	S	MS	MS
Procurement	S	MS	MS	MS
Monitoring and Evaluation	S	S	S	S

BASIC INFORMATION – ADDITIONAL FINANCING (Additional Financing for Institutional Foundations to Improve Services for Health - P177050)

Project ID	Project Name	Additional Financing Type	Urgent Need or Capacity Constraints
P177050	Additional Financing for Institutional Foundations to Improve Services for Health	Cost Overrun/Financing Gap, Restructuring, Scale Up	No
Financing instrument	Product line	Approval Date	
Investment Project Financing	IBRD/IDA	28-Sep-2022	
Projected Date of Full Disbursement	Bank/IFC Collaboration		

31-Dec-2026	No		
Is this a regionally tagged project? No			

Financing & Implementation Modalities

[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a Non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made disaster
[ ] Alternate Procurement Arrangements (APA)	[ ] Hands-on Expanded Implementation Support (HEIS)
[✓] Contingent Emergency Response Component (CERC)	

Disbursement Summary (from Parent ISR)

Source of Funds	Net Commitments	Total Disbursed	Remaining Balance	Disbursed
IBRD				%
IDA	54.00	4.64	49.36	8.6 %
Grants				%

PROJECT FINANCING DATA – ADDITIONAL FINANCING (Additional Financing for Institutional Foundations to Improve Services for Health - P177050)

FINANCING DATA (US$, Millions)

SUMMARY (Total Financing)

	Current Financing	Proposed Additional Financing	Total Proposed Financing
Total Project Cost	84.00	1.00	85.00
Total Financing	54.00	31.00	85.00

of which IBRD/IDA	54.00	20.00	74.00
Financing Gap	30.00	-30.00	0.00

DETAILS - Additional Financing

World Bank Group Financing

International Development Association (IDA)	20.00
IDA Credit	20.00

Non-World Bank Group Financing

Trust Funds	11.00
Global Financing Facility	11.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Liberia	20.00	0.00	0.00	20.00
National PBA	20.00	0.00	0.00	20.00
Total	**20.00**	**0.00**	**0.00**	**20.00**

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any other Policy waiver(s)?

[ ] Yes [✓] No

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
Cultural Heritage	Relevant
Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Collins Chansa	Team Leader (ADM Responsible)	Health Economist	HAWH3
Kazumi Inden	Team Leader	Public Health	HAWH2
Oyewole Oluyemi Afuye	Procurement Specialist (ADM Responsible)	Senior Procurement Specialist	EAWRU
MacDonald Nyazvigo	Financial Management Specialist (ADM Responsible)	Financial Management	EAWG2
Akhilesh Ranjan	Social Specialist (ADM Responsible)	Social Development	SAWS1
Zinnah S Mulbah	Environmental Specialist (ADM Responsible)	Environmental Safeguards	SAWE4
Anna Gibson Conn	Team Member	GFF	HHNGF
Anthony Theophilus Seddoh	Team Member	Health	HAWH3
Baba Imoru Abdulai	Team Member	Procurement	EAWRU
Daniela Hoshino	Team Member	Program Assistant	HAWH3
Edith Ruguru Mwenda	Team Member	LEGAM	LEGAM
Genesis May Jopson Samonte	Team Member	GFF	HHNGF
Georgia Tammy Mitchell Quaye	Team Member	GFF Country Liaison Officer	HHNGF
Ines Melissa Emma Attoua Etty	Team Member	WFACS	WFACS
Lemu Ella Makain	Team Member	Program Assistant	AWMLR
Luis Camilo Osorio Florez	Team Member	Health Specialist	HAWH3
Monica Moura Porcidonio Silva	Team Member	Program Assistant	HAWH3
Munirat Iyabode Ayoka Ogunlayi	Team Member	GFF	HHNGF
Nicolas Rosemberg	Team Member	Health Economist	HAWH3
Seble Berhanu	Team Member	Analyst	HAWH3
Victoria Ewura Ekua Wood	Team Member	LEGAM	LEGAM
Zephaniah J Smith	Team Member	Financial Management	EAWG2

Extended Team

Name	Title	Organization	Location

I. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING

A. Introduction

1. **This Project Paper seeks the approval of the World Bank's Board of Executive Directors to provide additional financing (AF) in the amount of US$20.00 million from the International Development Association (IDA). The Paper also seeks the approval of the Western and Central Africa Regional Vice President for a trust fund grant in the amount of US$11.00 million from the Global Financing Facility (GFF) for Women, Children and Adolescents, which will co-finance the Project. The proposed AF will also include restructuring of the Liberia Institutional Foundations to Improve Services for Health Project (IFISH, P169641).** The parent Project, with a proposed budget of US$84 million, was approved with a financing gap of US$30 million as only US$54.00 million was provided from the IDA Scale-Up Window. The parent Project was approved on May 21, 2020 and became effective on February 2, 2021. The main purpose of the AF is to fill the existing financing gap and to cover costs associated with expanding existing activities under the parent Project, and introduction of new ones. Through the restructuring, the proposed AF also seeks to address implementation challenges and the disrupted access to essential health services due to the COVID-19 pandemic. To increase operational efficiency, the following changes will be made: (i) reallocation of funds; (ii) change in financing modality; (iii) revision of disbursement categories; and (iv) revision of the results framework.

B. Country and Sectoral Context

2. **Liberia is still striving to overcome the effects of two devastating civil wars (1989-1996 and 1999-2003), the Ebola Virus Disease (EVD) (2014-2016), and the ongoing COVID-19 pandemic.** Consequently, over the past two decades (2001-2020), the annual average Gross Domestic Product (GDP) growth rate has been a meagre 2.1 percent—far below the annual average GDP growth rate of 3.7 percent for low-income countries over the same period.[1] While there was increased economic growth immediately after the end of the EVD outbreak in 2017, growth has been low and actually contracted by 2.5 percent and 3.0 percent in 2019 and 2020, respectively. This is far below the projected growth of 1.6 percent before the COVID-19 outbreak. As such, it is evident that the COVID-19 pandemic has exacerbated Liberia's pre-existing macroeconomic vulnerabilities. Liberia is also at moderate risk of external debt distress and at high risk of overall public debt distress. The country's total public debt (from both domestic and external sources) accounted for about 60 percent of the GDP in 2020 from 32.6 percent of GDP in 2018 with about 90 percent of the total external debt from multilateral creditors.[2]

3. **Poverty in Liberia is widespread with more than half of the population living below the national poverty line in 2016.** This translates into roughly 2.3 million Liberians who are unable to meet their basic needs. Poverty in Liberia is projected to have increased over the years, driven by volatile food prices, lower commodity prices for minerals, and the COVID-19 pandemic. For example, estimates from the World Bank

[1] Data extracted from World Development Indicators.
[2] World Bank. 2021. *Liberia Economic Update: Finding Fiscal Space.* Washington DC, World Bank.

show that the pandemic contributed to an increase in the proportion of households living below the international poverty line of US$1.9 per day from 44.4 percent in 2016 to 52 percent in 2021.[3] The COVID-19 high-frequency surveys conducted by the Liberia Institute of Statistics and Geo-Information Services also show that living standards of the Liberians have worsened. In the July 2021 round of the household survey, about 80 percent of the households reported that they were worried about not having enough food to eat; while the company survey showed that 35 percent of the businesses had reported a decline in revenue compared to previous months. The war in Ukraine has also led to an increase in the prices of fuel and rice. This is likely to increase the cost of health service delivery which will in turn affect access to health and nutrition services. For example, to respond to the negative effect of the war in Ukraine, by July 2022, the GoL had already increased the retail prices of gasoline and diesel per gallon by 26 and 32 percent, respectively.[4]

4. **Liberia has some of the worst reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) outcomes.** Liberia's maternal mortality rate at 742 deaths for every 100,000 live births is among the highest in the world.[5] The neonatal mortality rate (deaths within the first 28 days of life) is as high as 37 per 1,000 live births, and accounts for a third of all under-five deaths. Most of the mothers and newborns in Liberia die from preventable and treatable complications due to poor quality of health care during the antenatal, perinatal, and postpartum periods. The leading causes of maternal deaths are: hemorrhage (41.6 percent), sepsis (20.2 percent), eclampsia (17.2 percent), anemia (3.9 percent), ruptured uterus (3.0 percent), and obstructed labor (2.6 percent).[6] For newborns, the main causes are birth asphyxia (56.6 percent), neonatal sepsis (34.4 percent), preterm labor (2 percent), neonatal tetanus (1.3 percent), and aspiration pneumonia (1.3 percent).[7] In addition, owing to food insecurity at the household level, about 30 percent of children under the age of five are stunted[8] and at the risk of cognitive and physical limitations.

5. **Among the underlying causes of poor health and nutrition outcomes in Liberia is inadequate physical access to health facilities, insufficient and inequitably distributed health workers, and low quality of health care.** Most of the primary health facilities and hospitals are in poor physical conditions and are staffed with insufficient numbers of productive, responsive, and qualified health workers in critical areas. There are only 337 medical doctors, 858 midwives, and 2,440 nurses in the country. The total workforce density was estimated at 11.8 health workers per 10,000 population in 2016 (much lower than the recommended 23 per 10,000). There are also variances by county with Bomi and Montserrado having 15.7 and 14.9 health workers per 10,000 people as compared to Maryland and Grand Bassa at 8.5 and 8.0 health workers per 10,000 people, respectively. Additional 2,763 health workers are required to meet the minimum target by 2030.[9] People-centered health care needs are generally absent and interventions among the health workers are required in order to provide socio-culturally sensitive care without stigma

[3] World Bank Group. 2021. Poverty and Equity Brief Liberia. *https://povertydata.worldbank.org/poverty/country/lbr*
[4] World Bank. 2022. *Concept Note: Performance and Learning Review of the Country Partnership Framework.* Washington DC: World Bank.
[5] Liberia Demographic and Health Survey 2019-2020.
[6] Liberia Ministry of Health. 2020. Maternal and Neonatal Death Surveillance and Review Report. Monrovia: Liberia.
[7] ibid
[8] Liberia Demographic and Health Survey 2019-2020.
[9] Dahn B, Kerr L, Nuthulaganti T, Massaquoi M, Subah M, Yaman A, Plyler CM, Cancedda C, Marshall RE, Marsh RH. Liberia's First Health Workforce Program Strategy: Reflections and Lessons Learned. *Annals of Global Health*. 2021; 87(1): 95, 1–7. DOI: *https://doi. org/10.5334/aogh.3242*

and/or judgement, especially for adolescents. Poor quality of health care in Liberia can also be attributed to limited use of clinical guidelines and protocols by health workers; and infrequent review of maternal and newborn deaths. The quality of surgical care is also poor leading to a high prevalence of post-surgery complications and nosocomial infections. In addition, the available medical equipment is inadequate and/or obsolete while access to quality and efficacious medicines is low. Further, several patients experience delays when accessing health care.

6. **The COVID-19 pandemic has negatively affected access to RMNCAH-N services.** Liberia reported its first COVID-19 case on March 16, 2020, and by August 14, 2022, the country had recorded a cumulative total of 7,578 cases and 294 deaths.[10] Liberia has experienced secondary impacts of the outbreak which include: (i) shortage of essential medicines and medical commodities due to disruptions in the global supply chain; and (ii) reduced provision and access to essential health and nutrition services due to fear of infection, closure of health facilities, and the turning away of patients by health workers. For example, by April 2020, the decrease in utilization of key reproductive, maternal and child services in Liberia ranged from 4.8 percent to 33.9 percent as follows: pentavalent 3 vaccinations (-33.9 percent), outpatient consultations (-29.5 percent), Bacille Calmette-Guerin (BCG) vaccinations (-20.4 percent), fourth antenatal care visits (-17.3 percent), first antenatal care visits (-16.9 percent), postnatal care visits (-9.9 percent), family planning consultations (-5.3 percent) and institutional deliveries by skilled birth attendants (-4.8 percent).[11] Towards the end of July 2020, there were improvements in the utilization of maternal and child health services but the utilization levels generally remained below the pre-COVID-19 pandemic levels. As such, the cumulative reduction between March and July 2020 ranged from 1.9 percent to 9.1 percent across the indicators presented above, except for BCG vaccinations and family planning consultations which have rebounded.

7. **To minimize the adverse consequences of the COVID-19 crisis on RMNCAH-N and other essential health services in Liberia, service delivery modifications are required.** These modifications have to be contextualized and integrated with the overall epidemic response mechanism. Dedicated RMNCAH-N activities, including catch-up campaigns, are also required. Although the COVID-19 fully vaccination coverage in Liberia, estimated at 45 percent of the population on July 20, 2022, is far above the average of 16 percent for low-income countries (and average of 20 percent for Africa), more needs to be done.[12] Liberia seeks to increase COVID-19 vaccination coverage to 70 percent of the population by the end of 2022.

C. Performance of the Parent Project

8. **The IFISH Project was approved by the Board of the World Bank Executive Directors on May 21, 2020, became effective on February 2, 2021, and is expected to close on August 31, 2026.** The total cost of the Project is US$84 million out of which US$54 million was provided at approval, leaving a financing gap of US$30 million. The project development objective (PDO) of the parent Project is to improve health service delivery to women, children and adolescents in Liberia. The Project has four components, namely:

[10] *https://ourworldindata.org/coronavirus#explore-the-global-situation*
[11] Shapira, G., Ahmed, T., Drouard, S.H.P., Amor Fernandez, P., Kandpal, E., Nzelu, C., Wesseh, C.S., Mohamud, N.A., Smart, F., Mwansambo, C. and Baye, M.L., 2021. Disruptions in maternal and child health service utilization during COVID-19: analysis from eight sub-Saharan African countries. *Health policy and planning*, *36*(7), pp.1140-1151.
[12] *https://ourworldindata.org/coronavirus#explore-the-global-situation*

(a) Component 1: Improved service delivery (US$68 million: US$47.00 million IDA and US$21 million financial gap). This component uses the input-based financing mechanism. Component 1 has six subcomponents which finance: (i) procurement and installation of equipment for Phase 1 at the New Redemption Hospital in Caldwell, rural Montserrado County and the design, construction, and procurement and installation of equipment for Phase 2; (ii) training of undergraduate and postgraduate health personnel; (iii) provision of maternal, child and adolescent health services through performance-based financing (PBF) to primary health facilities and hospitals; (iv) operating costs for the community health program; (v) implementation of activities on adolescent health; and (vi) procurement of essential medicines and supplies.

(b) Component 2: Institutional strengthening to address key binding constraints (US$11 million: US$6.00 million IDA and US$5 million financial gap). This component uses the Disbursement-Linked Indicators (DLIs) financing mechanism. The component has five subcomponents which support: (i) development of standards and procedures to strengthen the country's health information management system; (ii) strengthening supply chain management; (iii) development and implementation of an effective human resource strategy and performance management strategy; (iv) strengthening coordination and implementation of school-based adolescent health programs; and (v) enhancing community and citizen engagement.

(c) Component 3: Project management (US$5 million: US$1.00 million IDA and US$4 million financial gap). This component uses the inputs-based financing mechanism. The component supports Project coordination and monitoring and evaluation.

(d) Component 4: Contingency Emergency Response (US$0.00). This is a fallback mechanism which allows the Government of Liberia (GoL) to request for a rapid reallocation of Project funds to respond to an emergency or crisis.

9. **In the last two Implementation Status and Results Reports (ISRs), progress towards achievement of the PDO for the parent Project was rated Satisfactory while Implementation Progress was rated Moderately Satisfactory.** As of August 15, 2022, only US$4.64 million (8.59 percent) of the total Project funds had been disbursed. Low disbursements and slow implementation of Project activities are due to: (i) a nine-month delay in achieving Project effectiveness; (ii) delayed completion of Phase 1 construction works at the New Redemption Hospital financed through the Ebola Emergency Response Project (EERP, P152359); and (iii) difficulty in implementing activities linked to the achievement of DLIs. Compounding the problem is that the parent Project is dependent on the completion of construction work under the EERP to disburse funds under Component 1. About 65 percent (US$35 million) of the total funds under the parent Project are allocated for the construction and equipping of the New Redemption Hospital in the following sequence: (i) procurement and installation of equipment for Phase 1; and (ii) civil works, procurement and installation of equipment for Phase 2. However, civil works under Phase 1 are financed through the EERP but the works are not yet complete. This has affected progress under the IFISH Project because the equipment for Phase 1 cannot be bought until civil works are completed; and Phase 2 cannot start until after Phase 1 is completed. The proposed AF integrates Phases 1 and 2 of the envisaged civil works, and the entire hospital is now expected to be completed by 2025.

10. **None of the DLIs under the Project have been achieved due to implementation and funding constraints.** Nonetheless, in an attempt to achieve the DLIs, the MoH used some resources from the GoL and other development partners to implement some of the activities covered by the DLIs under Component 2. The parent Project has six DLIs focusing on five areas, namely: (i) data availability and evidence-based decision making; (ii) drug availability and supply chain management; (iii) human resource management; (iv) adolescent health; and (v) citizen engagement. At Project inception, it was envisaged that resources would be disbursed upon achieving DLIs. However, by July 2022, no disbursement had been made. This could be attributed to inadequate counterpart resources from the GoL and other partners to finance the five areas targeted by the DLIs, complexity of putting in place a viable independent verification agency, and weak routine monitoring and evaluation systems. Consequently, funding from the GoL and other partners only covered some of the DLIs activities on data availability and use (DLI1), adolescent health (DLI4 and DLI6), and citizen engagement (DLI5). To address the issue of low disbursement and to accelerate implementation of activities covered by the DLIs, it has been agreed by the GoL and the World Bank to simplify the design, through the proposed AF, by removing the DLIs.

11. **The PBF scheme currently being implemented under the parent Project has contributed to increased access to quality healthcare at the primary and hospital levels.** The PBF covers 63 clinics and eight hospitals in seven counties, namely: Rivercess, Sinoe, Gbarpolu, Montserrado, Bong, Lofa, and Nimba. In three of these counties (Rivercess, Sinoe, and Gbarpolu), PBF is operational at both the clinics and hospitals. This represents 26 percent (1,338,007) of the total population (5,180,208) of Liberia.[13] Despite the negative effects of COVID-19 on health service delivery in Liberia, the average quality scores at the 63 primary health facilities and eight hospitals implementing PBF has been sustained at around 70 percent and 80 percent, respectively. This demonstrates the important role of the PBF scheme under the IFISH Project in preserving the gains which were achieved under the World Bank-supported Liberia HSSP (P128909).

12. **The overall performance on environmental and social standards (ESS) compliance of the parent Project is Moderately Satisfactory.** Through support from the parent Project, the National Healthcare Waste Management Plan (NHCWMP) has been finalized and disclosed; the Labor Management Procedures (LMP) have also been prepared and disclosed and its associated project workers grievance mechanism has been operationalized. However, the following environmental and social actions are still under development: (i) the Project Grievance Redress Mechanism (GRM) needs to be fully operationalized; (ii) the gender-based violence (GBV), Sexual Exploitation and Abuse and Sexual Harassment (SEA/SH) Action Plan needs to be adopted; and (iii) the implementation completion report on the Resettlement Action Plan needs to be submitted to the World Bank for approval. The GoL is committed to finalization of these documents as stipulated in the revised Environmental and Social Commitment Plan (ESCP) and Financing Agreement for this AF.

D. Rationale for Additional Financing and Restructuring

13. **The main purpose of the proposed AF is to fill the existing financing gap, cover costs associated with expanding coverage of existing activities under the parent Project and introduction of new activities and restructuring of the parent Project.** At approval, a financing gap of US$30.00 million was already

[13] Total population of Liberia in 2021.

articulated in the project appraisal document for the parent Project. As such, the decision to prepare AF for the Project was agreed upon in mid-2021. However, due to a limited IDA allocation for Liberia at that time, preparation of the AF was deferred to the 2022/2023 fiscal year. Consequently, apart from activities on PBF and project management, all other activities under the parent Project have been on hold since mid-2021. Furthermore, to address implementation challenges, the Project will also be restructured in order to: (i) increase allocative and technical efficiency for quality RMNCAH-N service delivery by reallocating funds and realigning activities across the components; (ii) improve operational efficiency by revising the financing modality; and (iii) improve monitoring and evaluation of the Project's performance by updating the Results Framework which is informed by a revised theory of change. On the demand side, the AF and restructuring are expected to increase effective coverage and quality of care through demand creation, citizen engagement, and by linking performance to financing through PBF.

14. **The AF and restructuring are backed by formal requests from the GoL to the World Bank dated July 8, 2021 and June 1, 2022**. In the first letter, the GoL requested for IDA and GFF funding to sustain the provision of essential health services, to support scale-up of high-impact interventions under the parent Project, and to integrate activities on health systems strengthening into a systematic approach towards achieving Universal Health Coverage (UHC). The follow-up letter sought support for the procurement and shipment of traditional childhood vaccines (BCG, measles, tetanus and diphtheria, and bivalent oral polio), following formal communication from United Nations Children's Fund (UNICEF) to the GoL on the cessation of financial support for the stipulated vaccines.

15. **Overall, it is envisaged that providing AF and restructuring the Project will help the GoL to address critical financing and implementation challenges in the health sector which have been aggravated by the COVID-19 pandemic.** Between July 2017 and June 2022, the overall government budget execution rate at eight hospitals and three counties (Rivercess, Sinoe, and Gbarpolu) where the World Bank has been supporting PBF implementation was only 73 percent (79 percent at the eight hospitals and 39 percent in the three counties). Advent of the COVID-19 pandemic has further reduced predictability of funding from both the GoL and development partners, leading to supply-side constraints and forgone health care. For example, some of the partners have discontinued financing of critical inputs to child health and survival (i.e., traditional vaccines) and this has further dented the already low and dwindling financing capacity of the GoL. Thus, in response to the government's request, the IDA credit and GFF grant for essential health services seek to address critical financing and implementation challenges in the health sector which have been aggravated by the COVID-19 pandemic. It is anticipated that the activities which will be financed through the proposed AF will help to sustain provision of essential healthcare due to unpredictable, reduced, and/or ceased funding.

16. **The AF and restructuring are also expected to improve allocative efficiency by facilitating implementation of the harmonized PBF framework.** Specifically, with the harmonized PBF framework in place, the World Bank will expand PBF coverage at all levels from three to six counties and sustain its implementation at the Old Redemption Hospital in Montserrado county. It is further anticipated that other partners such as the United States Agency for International Development (USAID) will implement PBF in the remaining eight counties which will improve alignment and aid effectiveness through reduced duplication of activities and funding. The Project will also avert costs associated with verification of PBF results since USAID will be hiring an independent verification firm to serve the needs of all PBF schemes in the country under the national PBF program. By scaling up PBF, it is also envisaged that equity in

geographical access will be improved. This is because the restructured Project will include areas which were not originally covered in the parent Project (such as Maryland and Grand Kru) with high poverty levels and poor health and nutrition outcomes. The third county where PBF will be delivered is Bomi which is also a hard to live area with inadequate health and other basic social services. The PBF is also expected to facilitate improvements in quality of care by strengthening primary health care systems and its referral to the secondary care, especially in the fields of maternal and newborn care. To sustain PBF in the health sector, the proposed AF will support activities to mainstream PBF into the government health system.

17. **As the RMNCAH-N Investment Case (IC) 2016-2020[14] came to an end, Liberia received approval for a grant financing from the GFF to support the delivery of essential health and nutrition services and implement the country's revised RMNCAH-N IC.** The GFF is a country-led multi-stakeholder partnership housed at the World Bank, committed to ensuring that all women, children and adolescents survive and thrive. In order to support GFF partner countries in the wake of the COVID-19 pandemic, the GFF is supporting investments to maintain the provision of essential health and nutrition services at community and primary care levels by contributing to health systems redesign and resilience, and by enhancing quality of service delivery. This is critical for Liberia where the COVID-19 pandemic led to shortages of essential medicine and supplies, closures of medical facilities, and disruptions in the provision of essential health services. Thus, the grant from the GFF will support the provision and utilization of quality health and nutrition services in Liberia. GFF processes will also contribute to enhancing the GoL's multisectoral coordination and stakeholder engagement to optimize financing for the RMNCAH-N IC in the country under the common goals for improved health and wellbeing of women, children, and adolescents. The improved alignment under the government's leadership will also mobilize technical expertise from other partners to leverage global and regional best practices, which will facilitate evidence-based decisions for institutional capacity building and reforms towards the attainment of UHC.

II. DESCRIPTION OF ADDITIONAL FINANCING

A. Proposed Changes

18. **The Project will be provided with AF and restructured to facilitate systems strengthening, improved service delivery, and achievement of better health and nutrition outcomes in the country.** The AF will be allocated to the revised Components 2, 3, and 4 of the Project while the restructuring will consist of: (i) realignment and expansion of existing activities, and introduction of new activities; (ii) reallocation of costs across the components and disbursement categories; (iii) changing the financing modality under Component 2 from DLIs to input-based financing; (iv) revision of disbursement categories; and (v) revision of indicators and targets in the results framework to account for realigned and new activities. The PDO and closing date for the Project will not be changed. To illustrate how the proposed interventions will lead to better health outcomes, the theory of change has been revised (Figure 1).

19. **Realignment, expansion and introduction of new activities.** A summary of the changes is provided below.

[14] Republic of Liberia. Investment Case for Reproductive, Maternal, New-Born, Child, and Adolescent Health 2016-2020. Available at *https://www.globalfinancingfacility.org/sites/gff_new/files/Liberia-Investment-Case.pdf*

(a) Component 1
   i. Change the title for Component 1 from "Improved service delivery" to "Improved health infrastructure" to be in line with the revised activities.
   ii. Under Subcomponent 1.1, streamline the construction and equipping of the New Redemption Hospital by having all the various departments originally envisaged under Phases 1 and 2 incorporated as a single multi-purpose unit. This will make it possible to undertake the construction, and procurement and installation of equipment at the same time.
   iii. Rephrase Subcomponent 1.1 in line with revised activities from "Operationalizing new Redemption Hospital Phases 1 and 2" to "Construction and equipping of the New Redemption Hospital."
   iv. Create a new Subcomponent 1.2 to cater for new activities on rehabilitation and extension of existing primary healthcare infrastructure.
   v. Move original subcomponents 1.2, 1.4, 1.5, and 1.6 to Component 2.
   vi. Move Subcomponent 1.3 to new Component 3.

(b) Component 2
   i. Change the title for Component 2 from "Institutional strengthening to address key binding constraints" to "Improve health service delivery" to be in line with the revised activities.
   ii. Integrate original Subcomponents 1.2, 1.4, 1.5, 1.6, 2.4, and 2.5 under revised Subcomponents 2.1, 2.2, and 2.3. Under Subcomponent 2.2, the Project will finance the procurement and shipment of essential medicines and RMNCAH-N products, routine vaccines and equipment.
   iii. Move original Subcomponent 2.1 to new Component 4 (originally Component 3).

(c) Component 3
   i. Change the title for Component 3 from "Scaling-up the successes of PBF" to "Strategic purchasing and equity in health financing" to be in line with the revised activities.
   ii. Original Component 3 renumbered as Component 4.
   iii. Integrate Subcomponent 1.3 under new Subcomponent 3.1. Under this subcomponent, PBF will be scaled-up from three to six counties.
   iv. Create Subcomponent 3.2 to support implementation of the health financing policy and strategy.

(d) Component 4 (revised, originally Component 3)
   i. Change the title for the original Component 3 from "Project management" to "Project management, monitoring and evaluation" to be in line with the revised activities.
   ii. Integrate original Subcomponents 2.1, 3.1 and 3.2 under new Subcomponent 4.1
   iii. Create Subcomponent 4.2 to support monitoring and evaluation of the provision of essential health services

(e) Component 5 (originally Component 4)

20. **Reallocation of costs across components and allocation of the AF.** Firstly, to accommodate the restructuring, US$9.00 million will be reallocated from Component 1 to Component 2 (US$6.00 million) and Component 3 (US$3.00 million). Secondly, US$1.00 million will be reallocated from Component 2 to

Component 4. Thirdly, the proposed AF of US$31.00 million will be allocated to Components 2, 3, and 4. Table 1 summarizes the proposed revisions.

21. **Change the financing modality under Component 2 from DLIs to input-based financing.** All DLIs will be removed and the traditional investment project financing approach will be used. However, the key areas originally targeted for improvement through the DLIs will remain, and the results framework will be revised to monitor and evaluate performance closely.

22. **Changes in Disbursement Categories.** Given the changes to the financing modality, creation of new components, and reallocation of funds across the components; some categories will be added while others will be removed. Further, given the grant funding from the GFF which will be part of the AF, percentage allocations across the categories for each funding source will be updated.

23. **Modification of the Project's Results Framework.** The Results Framework will be updated to align investments under the Project to realistic and achievable performance indicators and targets as outlined in existing national policy documents and strategic plans.

B. Description of Revised Components

COMPONENT 1 (REVISED): Improve health infrastructure (total US$38.00 million IDA, of which AF US$0.00)

Subcomponent 1.1: Construction and equipping of the New Redemption Hospital (total US$35.00 million IDA, of which AF US$0.00)

24. **The restructured Project will finance an integrated design of the New Redemption Hospital by integrating Phases 1 and 2 into one multi-purpose unit.** This means that all the departments, utilities, staff accommodation and other amenities envisaged under Phases 1 and 2 will be undertaken at the same time. Depending on the available resources, integrated design, and bills of quantities; the civil works will include the following departments: obstetrics and gynecology; pediatric; internal medicine; general surgery; ear, nose and throat; trauma and emergencies; ophthalmology; and dental. The civil works will also include accompanying wards, kitchen, and laundry rooms, and apartments for staff accommodation. In an event that some funds remain after the hospital is constructed and equipped, such funds will be used to meet the initial operational costs for running the hospital. This includes purchase of drugs and medical commodities, salaries for critical health workers not on the government payroll, office equipment and supplies, water and electricity connectivity, and other logistics.

25. **To facilitate the operationalization of the new hospital, Project funds will be used to engage an international consultant to undertake a rigorous evaluation of the needs to run the hospital.** The evaluation will look at the required human resources, maintenance, drugs and medical supplies, kitchen and laundry, and other recurrent operational costs. The main deliverable of this evaluation will be an investment plan highlighting the total and specific costs to run each department at the hospital; total and specific human resource needs for each department; available funds; and resource mobilization activities. Considering that the hospital provides an opportunity for training and professional development of medical personnel, the evaluation will also highlight linkages to the nursing and medical schools in the country and

required investments. This evaluation will be undertaken immediately after the consolidated design is finalized. This will allow the Ministry of Health (MoH) to use the investment plan to start mobilizing human and financial resources to operationalize the hospital way before the construction and equipping of the hospital is completed in 2025.

Subcomponent 1.2: Rehabilitation and extension of infrastructure at primary health facilities (total US$3.00 million IDA, of which AF US$0.00)

26. **This subcomponent aims to improve functionality and physical access to healthcare by supporting the rehabilitation and extension of health infrastructure at existing primary health facilities.** The support will be targeted at the six counties implementing PBF under the Project, namely: Gbarpolu, Rivercess, Sinoe, Bomi, Grand Kru, and Maryland. The number of primary health facilities which will be supported will depend on the need, available resources, scope of work, and bills of quantities. Depending on the availability of funds, the Project will also finance the procurement and installation of basic equipment at the rehabilitated primary health facilities. Equally, some basic houses for health workers could be constructed at the targeted clinics. The eligible number of facilities, list and value of equipment to be bought will be provided by the MoH after undertaking an assessment. To improve the functionality of service delivery institutions, the Project will also finance logistical needs of county health teams, hospitals and clinics.

COMPONENT 2 (REVISED): Improve health service delivery (total US$23.00 million, of which AF US$12.00 million: US$8.00 million IDA and US$4.00 million GFF)

Subcomponent 2.1: Community and adolescent health care (total US$6.50 million, of which AF US$3.00 million GFF)

27. **This subcomponent will finance costs on community health, adolescent health, and citizen engagement with a view of improving the quality of RMNCAH-N services in the country.** On community health, the activities that will be implemented will be guided by the community health strategy and the revised RMNCAH-N IC. Furthermore, considering the critical role of PBF in fostering public financial management (FM) and functionality of the referral system, community health programs which will be supported under the Project will be aligned with the PBF. As such, a large part of the support towards the Community Health Assistant (CHA) program under the Project will be undertaken in counties where the Project will be implementing PBF. Nonetheless, consideration will be made for support in counties with no funding for community health programs from other partners and/or areas where funding from partners will cease during the life of the Project. Given the erratic supply of commodities for the community health services program, the Project will also procure the commodities in Project areas. Targeted trainings for CHAs on climate emergency preparedness and response will also be provided.

28. **This subcomponent will also finance interventions on adolescent health for both in-school and out-of-school youths.** To achieve this, a package of evidence-based interventions will be implemented at schools and in the communities with an aim to contribute to the reduction of the adolescent fertility rate (births per 1,000 women ages 15-19), early marriages, malnutrition, stillbirths, and maternal and neonatal mortality. The Project will support various units at the MoH, an experienced non-governmental organization (NGO), community and traditional leaders, and viable women empowerment programs to

implement behavioral change activities in the communities. The Project will also finance activities to improve sexual and reproductive health that will be undertaken jointly by the MoH; Ministry of Education; and the Ministry of Gender, Children, and Social Protection. These activities will be targeted at institutions and programs which harbor adolescents such as health facilities, schools, universities, churches, mosques, youth clubs; and through programs and interventions at community level. The activities on adolescent health that will be undertaken under the proposed Project are also expected to complement activities under the Liberia Women Empowerment Project (P173677), the Liberia Social Safety Net Project (P155293), and Ministry of Education programs on adolescent girls and women empowerment.

29. **This subcomponent will also support activities to strengthen citizen and stakeholder engagement by improving access to information and capturing the voice and feedback of the citizenry.** Activities on citizen engagement under this subcomponent will be complemented by activities under subcomponents 3.1 (PBF), and Component 4 (project management and monitoring and evaluation). The first set of activities will focus on information sharing and awareness-raising through household visits. The household visits will also provide an opportunity to obtain, act, and deliver feedback to the communities during subsequent visits. In this regard, the Project will finance the printing and dissemination of critical information on RMNCAH-N, household visits, and consolidation of data from the household visits for review and action during country platform meetings. Resolutions from the country platform meetings will be provided to the communities so that they are aware of action taken and progress made.

30. **The Project will also support activities to enhance consultation and collaboration with community members (including trained traditional midwives) through Health Facility Development Committee (HFDC) meetings.** These activities are expected to empower citizens, especially women and young girls, to make informed decisions on RMNCAH-N. The Project will also facilitate independent or third-party monitoring by partnering with local organizations in undertaking community health surveys, focus group discussions, and client satisfaction surveys.

Subcomponent 2.2: Improve availability of essential medicines and RMNCAH-N products, routine vaccines, equipment, and logistics (total US$12.50 million, of which AF US$8.00 million IDA)

31. **This subcomponent will finance costs for the procurement and supply of essential medicines, RMNCAH-N products, routine vaccines, non-drug consumables, and basic equipment for primary health facilities.** The aim is to increase the availability for essential medicines, traditional childhood vaccines, and reproductive health commodities at all primary health facilities so as to save the lives of women, children and adolescents. This will include antimalarials, oxytocin, misoprostol, magnesium sulfate, antibiotics, intravenous fluids, oxygen, blood, among others. The annual drug replenishment to facilities will be linked to drug consumption patterns. The Project will also provide funding to the National Blood Services and Transfusion Program to ensure availability of safe blood and blood products in the country. This will include technical assistance to develop, update, and/or operationalize policies and plans on safe blood and blood products. To enhance management of the supply chain, the Project will support activities that strengthen forecasting and quantification, procurement, logistics management, and resource mobilization for essential medicines, supplies and commodities. Technical assistance on climate sensitive distribution planning will also be provided.

32. **The procurement and shipment of routine childhood vaccines will only include the following vaccines: BCG, measles, tetanus and diphtheria, and bivalent oral polio vaccine.** These vaccines will be procured through UNICEF's supply division. The Project will also provide funds for ancillary supplies, customs clearing and handling, and deployment of the vaccines. To ensure sustainability in childhood vaccine financing, the GoL will commit to an annual increase in the government budget for childhood vaccines as highlighted in the Project's results framework.

Subcomponent 2.3: Improve knowledge and skills in training and management of Human Resources (total US$4.00 million, of which AF US$1.00 million GFF)

33. **This subcomponent will support costs related to the implementation of Liberia's Health Workforce Program Strategy.** Creating and implementing effective strategies for human resource for health management will facilitate equitable distribution and retention of health workers at all levels of the health system. This will also address disparities in staffing levels, skills-mix, and workloads by geographic location. Through this subcomponent, funds will be provided to develop staffing norms which will then be used to map existing health workers and to identify vacancies. Based on the vacancies, the MoH is expected to deploy qualified health professionals to the most deprived and climate-vulnerable areas. Furthermore, the Project will support the GoL in increasing the proportion of female health workers in-post. This will help to reduce the gender gap, increase demand for health services by women and girls, and address underlying barriers to access.

34. **The Project will also enhance management and service delivery skills at health facilities by funding programs for equitable distribution of health workforce and efficient delivery of services.** Special emphasis will be placed on providing technical assistance towards the development/revision of training curricula and improving the quality of pre-service and in-service training at nursing and midwifery schools. This will include provision of specialized training in pediatrics, obstetrics, gynecology, and other critical areas. The Project will also consider support for medical education, mentorship, and continuous professional development. The health workers will also be trained in climate emergency preparedness and response. The training will include actions to take at health facilities and in communities in preparation and response to climate shocks. To achieve value for money, the trainees will be required to accept posting to remote and climate-vulnerable areas. The Project will also support interventions to upgrade skills laboratories and libraries at some of the nursing and midwifery training facilities.

COMPONENT 3 (REVISED): Strategic purchasing and equity in health financing (total US$18.50 million, of which AF US$15.50 million: US$10.50 million IDA and US$5.00 million GFF)

Subcomponent 3.1: Expand coverage of PBF (total US$18.00 million, of which AF US$15.00 million: US$10.00 million IDA and US$5.00 million GFF)

35. **The Project is currently supporting the implementation of PBF at clinics and hospitals with a focus on RMNCAH-N services.** USAID is also implementing PBF in eight out of the 15 counties in the country but is using a different model. The MoH has been working with the World Bank, USAID and other partners in developing a harmonized national PBF manual that is expected to be used for the implementation of PBF in the country. In line with the PBF harmonization process, PBF activities under the Project will be drawn from the national PBF manual. Further, the Project will expand PBF coverage at clinics, hospitals,

and county health teams from three to six counties and sustain its implementation at the Old Redemption Hospital in Montserrado County. On the other hand, USAID is expected to implement PBF in counties where it is currently operating, including taking over the World Bank-supported PBF at four hospitals. USAID is also expected to finance the costs for hiring a national verification agency (NVA) which will serve the needs of all PBF activities in the country, including the ones supported by the World Bank. Project funds will be used to support the revision of the national PBF manual (if need arises), and to review working arrangements with the NVA. In an event that the NVA is not functional at any period of project implementation, project funds could be used to hire a separate verification entity to serve the needs of the Project.

36. **The full design features of the PBF model that will be implemented will be articulated in the revised Project Implementation Manual (PIM).** This includes: the regulator, fundholder, purchaser, service providers, contracting process, quantity and quality indicators, unit prices, verification mechanism, payment and FM, use of funds, and so forth. To enhance the effectiveness of the national PBF implementation process, project funds will be used to finance regular joint reviews of PBF implementation by the MoH in collaboration with USAID and other partners. It is anticipated that having joint reviews will encourage exchange of ideas, documentation, learning, and ownership of the PBF by the MoH. As part of this process, a roadmap for mainstreaming the PBF into the government structures will be developed. The MoH will also develop a mechanism for tracking funding flows from the government and other sources to counties implementing PBF under the Project. This includes tracking budgetary allocations and execution at primary health facilities, county level, and hospitals.

37. **To increase community participation and citizen engagement, all the clinics implementing PBF will be required to have functional HFDCs.** As part of the PBF implementation process, checklists will be used to assess the functionality of the HFDCs by looking at the frequency of having HFDC meetings, actions taken reports, and effectiveness of the feedback mechanisms.

Subcomponent 3.2: Support implementation of the health financing policy and strategy (total US$0.50 million, of which AF US$0.50 million IDA)

38. **To move towards UHC, the GoL has expressed a need to establish the Liberia Health Equity Fund aimed at enhancing mechanisms for pooling funds and purchasing health services.** The Project will provide resources towards the design and establishment of the fund including the recruitment of consultants, workshops and meetings, and exchange visits. This includes a feasibility study and development of policies, regulations, and organizational arrangements. Depending on the availability of resources under the Project, funds will also be provided for identifying sources of funds (including contributions and premiums), development of eligibility criteria and/or benefit package, etc.

COMPONENT 4 (REVISED): Project management, and monitoring and evaluation (total US$5.50 million, of which AF US$3.50 million: US$1.50 million IDA and US$2.00 million GFF)

Subcomponent 4.1: Project coordination and support to implementing units (total US$4.00 million, of which AF US$2.00 million: US$1.50 million IDA and US$0.50 million GFF)

39. **This subcomponent will finance costs related to the operations of the Project Implementation Unit (PIU), the Project Financial Management Unit (PFMU), and selected units supporting implementation of project activities.** This includes costs for staffing (salaries for local and international consultants), technical assistance, logistics and communication, office equipment and supplies, and utilities such as fuel for generators and vehicles. Costs for internal and external audits, training, seminar and workshops, and fiduciary management will also be financed. The PIU will also provide training and technical support to implementing agencies to enhance the quality of project implementation. This will include capacity building on key coordination functions and processes.

40. **The Project will also finance costs related to the development, revision, and monitoring of the implementation of ESS instruments.** This includes the Environmental and Social Management Plan (ESMP); NHCWMP; LMP; stakeholder engagement plan (SEP); GBV, SEA/SH action plan; etc. The PIU will also ensure that the GRM is fully functional at all levels of the health system. Further, the PIU will monitor implementation of activities on climate adaptation and mitigation under the Project.

41. To monitor progress towards achievement of the PDO, activities related to routine monitoring of the Project's result framework, supervision, and assessment visits to implementing counties, and infrastructure subprojects will be financed. Funds will also be provided for documentation of progress, lesson learned and best practices, and for the mid-term review and final evaluation of the Project.

Subcomponent 4.2: Monitoring and evaluation of the provision of essential health services (total US$1.50 million, of which AF US$1.5 million GFF)

42. **This subcomponent will support the development of standards and procedures to enhance data quality and monitoring and evaluation of the provision of essential health services particularly RMNCAH-N services.** This includes support for systems improvements in routine data collection, analysis, and use. In this regard, three key data generation and management units will be supported, namely: the Health Information Systems Unit, Monitoring and Evaluation Unit, and the Supply Chain Management Unit. On health information, support will be provided to ensure real-time collection of data from the District Health Information System 2 (DHIS-2) through an Application Programming Interface. To enhance capacity in data analysis and use, support will be provided to contextualize the data to identified needs at the MoH. This will include support towards data triangulation and development of a data use plan. To complement and/or triangulate data from the DHIS-2, the Project will support health facility phone surveys. Through the health facility phone surveys, the MoH will be able to gauge the availability of RMNCAH-N services and quality of care, stock-out of essential medicines and other medical supplies, etc. Furthermore, costs related to the production of dashboards to visualize performance on RMNCAH-N, drug supply, and PBF implementation will also be supported.

43. **Through the Family Health Division, the Project will finance costs for holding regular county platforms meetings at both central and county levels to review performance on key RMNCAH-N indicators.** Apart from government officials and development partners, representatives from civil society organizations (CSOs), women groups, and the private sector will participate in the country platform meetings to provide feedback on project implementation. In addition, funds will be provided to hold focus group discussions with CSOs and women groups on the delivery of RMNCAH-N under the Project. This is expected to increase citizen engagement and accountability for performance by providing: (i) an

opportunity to discuss project impacts and concerns with project beneficiaries and project affected people, and (ii) feedback on action taken.

44. **To facilitate deep engagement and consensus on key issues on RMNCAH-N, the Project will also support a series of joint technical discussions and data reviews bi-annually.** The outcomes from the technical discussions will be presented for endorsement and action to the Health Partners Group meetings, and senior management of the MoH. The Project will also support the implementation of agreed actions from the joint technical discussions and data reviews. This will include following-up on recommendations on disruptions of essential health services, lag in service coverage, and other implementation challenges.

45. **Given the importance of maternal and perinatal death surveillance and response (MPDSR) reviews in identifying and addressing causes of maternal and perinatal deaths, the Project will finance a minimum of two reviews each year.** Further, the Project will support activities on civil registration and vital statistics (CRVS) aimed at increasing the number of births and deaths registered in the country. Some of the activities on CRVS that could be undertaken include: (i) training on medical certification of causes of death; (ii) analysis of data on births, deaths and causes of death for data that has already been collected; (iii) dissemination and data use at the national and subnational levels; and (iv) mapping of business processes for births and deaths registration. Lastly, funds will be provided to the Family Health Division to monitor the provision of RMNCAH-N services, and to undertake technical support visits.

COMPONENT 5: Contingent emergency response component (US$0.00)

46. **This component is included in accordance with paragraphs 12 and 13 of the World Bank's policy on investment project financing.** There is a moderate to high probability that during the life of the Project, the country could experience an epidemic or outbreak of public health importance or any other emergency with the potential to cause adverse economic and/or social impact. If this happens, the GoL could make a request to the World Bank to support mitigation, response, and recovery activities in the areas affected by the emergency. This component provides for the GoL to request for rapid reallocation of project funds to respond promptly and effectively to an emergency or crisis.

C. Consistency with the Country Partnership Framework

47. **The proposed Project is consistent with the World Bank's Country Partnership Framework (CPF) FY19-24 (Report No. 130753-LR, October 26, 2018) for Liberia.** In particular, the Project contributes to Priority Policy Area B on Human Capital Development and Objective B2 which focuses on Expanding Healthcare Access and Improving Service Quality. The Project is also aligned with national policies and plans in the health sector in Liberia such as the National Health Policy and Strategic Plan.

Table 1: Proposed Reallocation of Funds Among Components and Allocation of the AF

Component Name	Original Cost (US$M)	Revised Cost (US$M)	AF (US$M)		Total Cost (Revised plus AF) (US$M)	Remarks
			IDA	GFF		
Component 1: Improve health infrastructure	**47.0**	**38.0**			**38.0**	
1.1: Construction and equipping of the New Redemption Hospital	35.0	35.0			35.0	Renamed

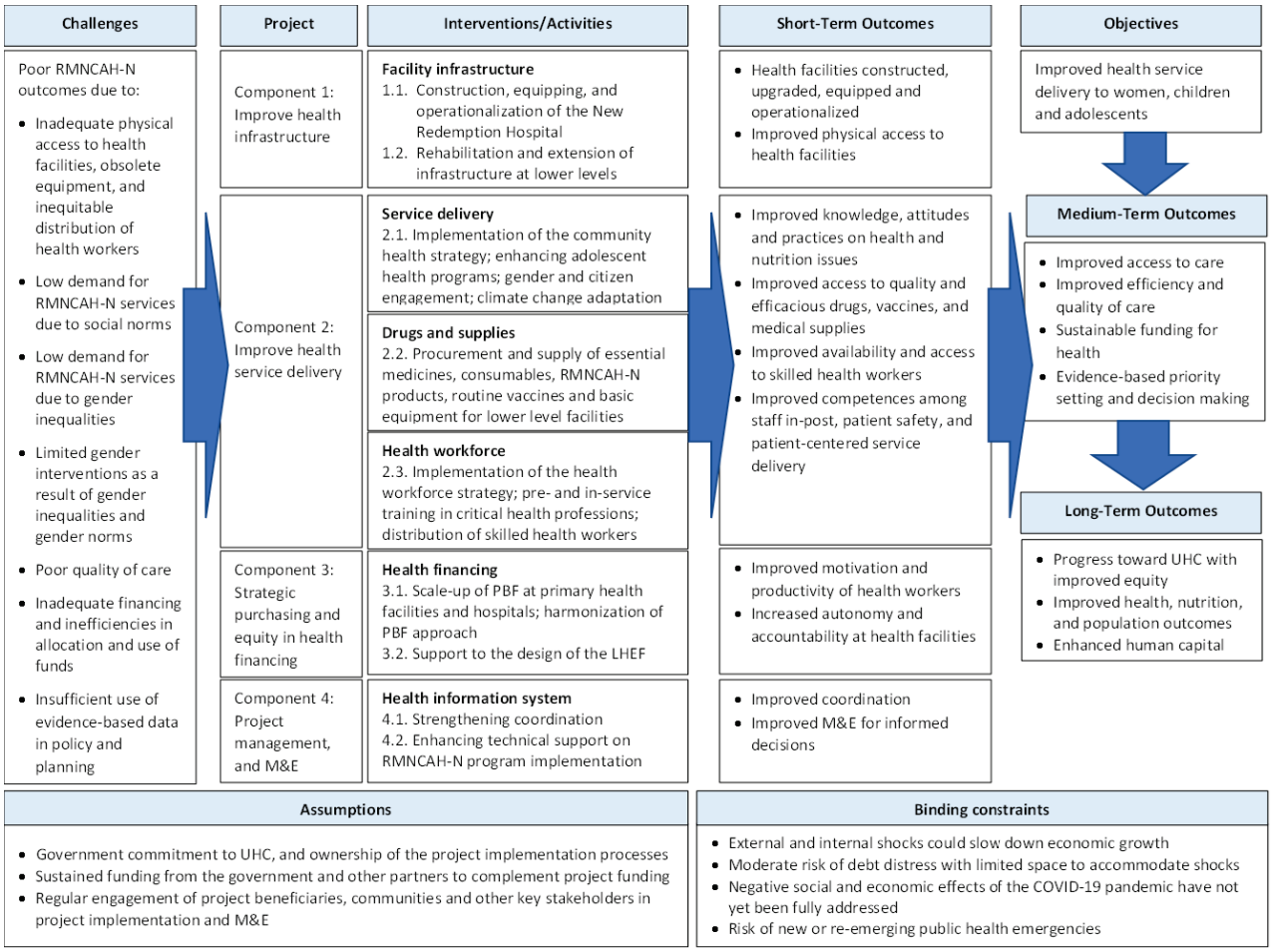
Component Name	Original Cost (US$M)	Revised Cost (US$M)	AF (US$M)		Total Cost (Revised plus AF) (US$M)	Remarks
			IDA	GFF		
1.2: Rehabilitation and extension of infrastructure at primary health facilities		3.0			3.0	New
1.2: Enhancing human resource skills	1.0					Moved to Component 2
1.3: Scaling-up the successes of PBF	3.0					Moved to Component 3
1.4: Support to the national Community Health Assistant Program	2.0					Moved to Component 2
1.5: Support for community and school health interventions to improve access to adolescent health care	2.0					Moved to Component 2
1.6: Improve availability of essential medicines and RMNCAH products	4.0					Moved to Component 2
Component 2: Improve health service delivery	**6.0**	**11.0**	**8.0**	**4.0**	**23.0**	
2.1: Enhanced and reliable data availability and evidence-based decision making	1.0					Merged with Subcomponent 4.2
2.1: Community and adolescent health care		3.5		3.0	6.5	New. Merged with Subcomponents 1.4; 1.5; 2.4; and 2.5
2.2: Improve availability of essential medicines and RMNCAH-N products, routine vaccines, equipment, and logistics	0.5	4.5	8.0		12.5	Merger of Subcomponents 1.6 and 2.2
2.3: Improve knowledge and skills in training and management of Human Resources	2.0	3.0		1.0	4.0	New. Merger of Subcomponents 1.2 and 2.3
2.4. Support for school-based interventions to improve adolescent health	2.0					Merged with new Subcomponent 2.1
2.5. Strengthened citizen engagement	0.5					Merged with new Subcomponent 2.1
Component 3: Strategic purchasing and equity in health financing	**0**	**3.0**	**10.5**	**5.0**	**18.5**	New
3.1: Expand coverage of PBF		3.0	10	5.0	18.0	Originally Subcomponent 1.3
3.2: Support implementation of the health financing policy and strategy			0.5		0.5	New
Component 4: Project management, and monitoring and evaluation	**1.0**	**2.0**	**1.5**	**2.0**	**5.5**	Original Component 3 merged with Subcomponent 2.1
4.1: Project coordination and support to implementing units	0.5	2.0	1.5	0.5	4.0	Merger of Subcomponents 2.1, 3.1 and 3.2
4.2: Monitoring and evaluation of the provision of essential health services	0.5			1.5	1.5	New
Component 5: Contingent emergency response component	**0**	**0**	**0**	**0**	**0**	Originally Component 4
Total	**54.0**	**54.0**	**20.0**	**11.0**	**85.0**	

D. Theory of Change

48. **The theory of change presented in Figure 1 depicts the key activities, expected results and outcomes under the proposed Project.** The Project will support activities to strengthen key components

of the health system through interventions to address the limitations and gaps highlighted above. As part of the efforts to improve effective coverage, proven highly cost-effective strategies will be implemented at scale from the community to hospital level, particularly in remote areas and link results to financing aimed at increasing productivity of health workers and accountability. These efforts are expected to contribute to improved health delivery for women, children and adolescents. The Project is then expected to increase access to care, increase allocative and technical efficiency and quality, move toward sustainable funding for health, and enhance evidence-based priority setting and decision making. Ultimately, the improved health systems will drive Liberia towards the attainment of UHC with equity; better health, nutrition and population outcomes; and increased human capital outcomes.

Figure 1: Revised Theory of Change



III. KEY RISKS

49. **The overall risk rating for the AF remains Substantial.** Substantial risks are rated in the areas of political and governance, macroeconomic, technical design of the Project, institutional capacity for implementation and sustainability, and fiduciary.

50. **Political and governance risks remains Substantial.** The Presidential Legislative Elections will take place in October 2023. Political and governance risks are primarily associated with corruption which robs citizens of access to vital services (including healthcare), subverts economic opportunities, and exacerbates inequalities and mistrust of the Government.[15] These are coupled with historical fragility to internal and external shocks that can hinder health service delivery. Key governance risks include: (i) inadequate accountability mechanisms to ensure that resources supporting the AF reach the intended health facilities and beneficiaries; and (ii) low priority given to public accountability and transparency in project management. To help mitigate these risks, the AF will support the implementation of World Bank anti-corruption strategies and national strategies and guidelines on anti-corruption. The Project will also monitor implementation closely, with clear reporting and decision-making arrangements.

51. **The macroeconomic risk remains Substantial.** During the remainder of the CPF, the economy is expected to recover, with growth projected at an average of 4.0 percent over the period 2021-2023. However, this is lower than was originally expected (5.3 percent). Moreover, the prolonged COVID-19 pandemic and war in Ukraine have strained revenue generation which has affected government's spending on health. This will have a negative impact on the delivery of essential health and nutrition services, including provision of salaries for health workers. The AF will mitigate these risks by: (i) continuously supporting the delivery of essential health and nutrition services and critical public health programs; (ii) scaling up PBF to enhance improved performance by health workers; and (iii) coordinating with other development partners to increase aid effectiveness by reducing duplication of funding and achieving economies of scale through joint planning and implementation.

52. **Risk for Sector Strategies and Policies remain Moderate.** Liberia has developed a number of policies and strategic plans including the National Health Policy and Strategic Plan and the Health Workforce Program Strategy. However, implementation of these policies and plans is a challenge due to inadequate financing and institutional capacity. This has contributed to gaps in stewardship and regulation of health service provision, and poor service delivery. The Project will mitigate this risk by supporting the implementation of existing policies and strategic plans. The Project will also support the GoL to update, design and operationalization policies and plans in areas requiring strategic direction.

53. **Technical design of project risk remains Substantial.** Despite the government's political commitments to achieving UHC, this is not fully translated into reality due to competing priorities. Though there is a clear need to invest in primary health care given the poor health and nutrition outcomes in the country, a cost-benefit analysis of investing in primary health care versus construction of the New Redemption Hospital was not undertaken. Furthermore, without sufficient financial and human resources to sustain the recurrent costs of the new hospital, it will be difficult for the Government to fully operationalize it. To address this challenge, the AF will finance a rigorous evaluation to determine the annual staffing needs and costs to run the hospital. Based on this evaluation, an investment plan will be produced and provided to the GoL to use for resource mobilization.

[15] Department of State, United States of America. (2022). Integrated Country Strategy. Retrieved online on August 16, 2022 from *https://www.state.gov/wp-content/uploads/2022/06/ICS_AF_Liberia_Public.pdf*

54. **Institutional capacity for implementation and sustainability risk remains Substantial**. The MoH through the PIU is currently implementing four World Bank-supported projects.[16] While this allows the MoH to gain experience in managing World Bank-supported operations, the limited capacity of the PIU may be overstretched. To mitigate this risk, the MoH has committed senior officials to constantly engage with PIU staff during project implementation. An international procurement consultant will also be hired to complement the work of the existing procurement officers under the PIU. Further, through the ongoing biweekly technical review meetings between the PIU and the World Bank, implementation challenges are discussed and addressed in a timely manner. Lastly, the design for the AF will be simplified to increase implementation efficiency.

55. **The fiduciary risk remains Substantial.** For FM, the risk is rated as Substantial. The PFMU, which is responsible for financial management of the Project, has experienced staff with the requisite education who gained experience with World Bank FM procedures through the implementation of the parent Project. The fund disbursement arrangement is adequate. The PIU and the PFMU have been working in coordination. Yet, delays in release of funds for activities and suppliers of procured items persist. Further, there were multiple requirements to verify PBF results in order to proceed payments to the health facilities, which modality and distinct roles of the PFMU were not clear. To mitigate these FM risks, the proposed AF will continue to use the PFMU and the General Auditing Commission (GAC) for external auditing. The roles of the PFMU and the PIU to verify the PBF results have been clarified.

56. **The procurement risk is rated as Substantial.** This rating is due to: (i) gaps in knowledge and experience of carrying out procurement activities in accordance with the World Bank Procurement Regulations for Investment Project Financing Borrowers, rules, and procedures (particularly regarding the new possibilities afforded by the Procurement Framework); (ii) limited procurement capacity; and (iii) inadequate experience in procurement of works, contract management and consulting services. The Project will continue to implement the following mitigation measures: (a) enhance the capacity of the PIU through training and coaching, and implementation support under the Project; (b) provide procurement training for PIU staff immediately after effectiveness and regular support during implementation; (c) recruit an international procurement consultant to complement the work of the existing procurement officers (recruitment has already commenced); (d) update the PIM to reflect the needs of the Project and current operational/procurement environment; (e) provide appropriate training in contract management and selection of consultants to PIU staff during the Project implementation in collaboration with the Ministry of Public Works; (f) provide the PIU with logistical and administrative support, including procurement of a high-volume scanner with internet service to enable migration from manual to electronic documentation and record keeping; and (g) the World Bank will carry out regular implementation support and annual procurement post reviews.

57. **The overall environmental and social risk rating remains Moderate.** The potential environmental risks and impacts under the proposed Project are related to new activities, mainly: (i) small-scale civil works at existing clinics involving the rehabilitation and extension of existing infrastructure, and construction of basic houses for health workers; and (ii) procurement and shipment of childhood vaccines. The potential environmental risks and impacts of the proposed civil works will include generation of noise, dust, vibration, and construction wastes. The civil works will also expose workers to occupational health and

[16] These include: (i) the Ebola Emergency Response Project (P152359); (ii) Regional Disease Surveillance Systems Enhancement Project II (P159040); (iii) the Liberia COVID-19 Emergency Response Project (P173812); and the parent Project (IFISH).

safety risks and hazards, including exposure to harmful substances, working at height, and hazards associated with the operation of machinery. To mitigate these risks, site specific ESMPs will be prepared prior to commencement of civil works at the targeted health facilities. The PIU will also ensure that the ESMPs are effectively implemented through regular monitoring and evaluation visits.

58. Administration of the vaccines will also generate millions of units of general, hazardous and infectious waste, including cotton swabs, vials, used syringes, needles and vaccine containers from inoculation centers. While these wastes can be disposed of carefully at medical waste facilities at clinics and hospitals across the country; healthcare waste management is still a challenge in Liberia. Some of the health facilities in the Project areas have poorly managed incinerators. To address the risks of vaccine-related healthcare waste, the MoH will ensure that all the beneficiary health facilities adhere to the NHCWMP, the National Infection Prevention and Control Guidelines, and the handbook on Safe Management of Wastes from Health-care Activities (2nd edition) by the World Health Organization. In addition, the MoH will be providing regular training in the management of medical waste at health facilities, use of waste bins and liners for waste collection, and routine use of personal protective equipment throughout the Project implementation period.

59. Assessment of the Project components and activities identified potential social risks such as: (i) non-discrimination and inclusion of vulnerable and disadvantaged groups. For example, there is a potential risk if the clinics are rehabilitated without consideration of the needs of persons with disabilities; (ii) low compliance to labor and working conditions of workers, including personnel under the PIU and contracted workers; (iii) SEA/SH during the provision of health services; (iv) possibility of child abuse during the implementation of activities on community and adolescent health; and (v) elite capture, and exploitation and discrimination of poor people. To address the social risks and impacts associated with the AF, the ESCP and SEP have been updated. Further, site-specific ESMPs will be prepared and implemented in order to mitigate site-specific social risks and impacts.

60. **Stakeholder's risk remains Low.** The Project has engaged closely with government institutions, development partners, NGOs, civil-society organizations, communities and other stakeholders. Given the wide variety of activities which will be undertaken under the proposed Project, continued engagement will be critical during implementation. As such, effective coordination is one of the key features of the design of the proposed Project. Further, considering that demand-generation activities often touch on gender, social norms, and beliefs, the Project design includes different platforms to strengthen citizen engagement, information sharing, and social awareness aimed at reducing the risks of conflicting interests of stakeholders and beneficiaries.

IV. APPRAISAL SUMMARY

A. Economic Analysis

Achievements and existing challenges in access to quality RMNCAH-N services

61. **Liberia has over the years made notable progress in increasing the provision of maternal, child health and nutrition services and this has contributed to reduced child and maternal mortalities.** For example, there has been an increase in the percentage of births taking place at health facilities from 37

percent in 2007 to 80 percent in 2019/2020. Consequently, the maternal mortality ratio reduced from 994 to 742 deaths per 100,000 live births between 2007 and 2019/2020, respectively. Despite this reduction, Liberia is still among the countries with the highest maternal mortality ratio in the world. This could be attributed to geographical disparities in access to maternal health services and poor quality of health care services. A comparative analysis by county shows that some counties still have very low institutional deliveries with the lowest being Gbarpolu at 50 percent coverage while Lofa has a 96 percent coverage. And due to poor quality of maternal health care, a significant portion of maternal deaths occur at health facilities with the leading causes of the deaths being preventable. Low provision of comprehensive emergency obstetric and newborn care (CEmONC) services is also one of the contributing factors to the high maternal deaths in Liberia. According to the latest harmonized health facility assessment for Liberia, only 16 percent of the health facilities offer CEmONC services.[17] And though some of the health facilities offer CEmONC services, most of the facilities lack competent and skilled staff and there are problems with anesthesia services, equipment, and blood and its products.

62. **The GoL also needs to invest in systems and interventions to reduce deaths among children below the age of five.** While there was a consistent reduction in the under-5 mortality rate from 110 to 93 deaths per 1,000 live births between 2007 and 2019/2020; the infant mortality rate reduced from 71 to 54 deaths per 1,000 live births between 2007 and 2013 after which there was an increase from 54 to 63 deaths per 1,000 live births between 2013 and 2019/2020.[18] The neonatal mortality rate also increased from 26 to 37 deaths per every 1,000 live births between 2013 and 2019/2020. Most of the deaths among the newborns and infants in Liberia are preventable and/or treatable. To address these bottlenecks, investing in systems and interventions that can increase the quality of health service delivery is needed. In addition, the COVID-19 pandemic has negatively impacted the provision and utilization of essential health and nutrition services in Liberia. Suffices to say that if the current progress on maternal and child health outcomes continues, Liberia will be unable to achieve UHC and the health-related sustainable development goals (SDGs). As observed by Laaser and others (2019), Liberia requires persistent efforts and international support to achieve the health-related SDGs.[19] This means that Liberia has to accelerate implementation of effective strategies to improve maternal and child health outcomes.

Available evidence on the impact of increased investments in RMNCAH-N

63. **Through empirical evidence, several highly cost-effective strategies to RMNCAH-N outcomes have been identified.** Firstly, childhood vaccination is a proven cost-effective intervention that can prevent the death and disabilities of under-5 children. Global evidence shows that 57 percent of the deaths which were averted among under-5 children between 2000 and 2019 can be attributed to increased vaccination coverage, mostly against measles.[20] By 2030, forecasts show that childhood vaccination coverage for traditional and new vaccines will increase and will lead to a 72 percent reduction in lifetime mortality among under-5 children.[21] For the sick children, implementation of the integrated management of childhood illnesses (IMCI) strategy has also proven to be a cost-effective intervention and it is associated

[17] 2022 Harmonized Health Facility Assessment for Liberia.
[18] Liberia Demographic and Health Survey 2019-2020.
[19] Laaser, U., Broniatowski, R., Byepu, S. and Bjegovic-Mikanovic, V., 2019. Delays in achieving maternal, newborn, and child health targets for 2021 and 2030 in Liberia. *Frontiers in public health*, *7*, p.386.
[20] Li, X., et al. (2021). Estimating the health impact of vaccination against ten pathogens in 98 low-income and middle-income countries from 2000 to 2030: a modelling study. *The Lancet*, *397*(10272), pp.398-408.
[21] ibid

with reduced under-5 mortality. A meta-analysis of IMCI studies from Bangladesh, India and Tanzania show that under-5 mortality can be reduced by 13 percent if the IMCI strategy is implemented.[22] Evidence also shows that about one-third of maternal deaths can be prevented by scaling-up family planning services which could delay motherhood, and avoid unintended pregnancies and unsafe abortions.[23] Further, to minimize the adverse consequences of the COVID-19 crisis on RMNCAH-N and other essential health services in Liberia, service delivery modifications are required. Dedicated RMNCAH-N activities such as catch-up vaccination campaigns are required but they have to be contextualized and integrated into the overall epidemic response mechanism or vice versa. The proposed Project will help the GoL to implement innovative and highly cost-effective RMNCAH-N strategies at scale from the community to hospital level, particularly in remote areas.

64. **Economic growth could be stimulated and poverty reduced by addressing maternal and child health challenges.** Studies show that one maternal death reduces GDP by US$0.42 per capita per year (in 2015 prices)[24] in Africa, while poor child health contributes to stunting, poor cognitive development, and poor performance at school.[25,26] In Uganda, a low-income country like Liberia, implementing highly effective interventions on maternal and newborn health costs only US$10,311 per death averted and US$177 per life-year gained. Given the above evidence, it is evident that investing in RMNCAH-N interventions as planned under the proposed Project can lead to better RMNCAH-N outcomes and increased human capital outcomes. As highlighted in the theory of change (Figure 1), the proposed Project is expected to increase the quantity and quality of RMNCAH-N outcomes by enhancing the health system and implementation of proven cost-effective interventions for improved service delivery.

Economic analysis of selected RMNCAH-N interventions

65. **A comprehensive economic analysis of the parent Project was not undertaken.** Thus, this has been done for the proposed Project to ascertain if the expected benefits from the planned investment outweigh the costs. The main assumptions are drawn from the theory of change (Figure 1) but the analysis only focuses on outcomes for women and children below the age of five. Specifically, the main outcomes of interest are the number of deaths and Disability Adjusted Life Years (DALYs) averted. By using DALYs, both the quantity and quality of life of women and children are incorporated. The main assumptions which were made when undertaking the analysis are provided in Box 1. By focusing on the most disadvantaged populations in the country, it is assumed that the Project would promote shared prosperity and equity.

[22] Gera et al. (2012). Integrated management of childhood illness (IMCI) strategy for children under five: Effects on death, service utilization and illness. *Cochrane Database of Systematic Reviews*, (9).
[23] Collumbien et al. (2004). Non-use and use of ineffective methods of contraception. In: Ezzati M, Lopez AD, Rogers A, Murray CJL, editors. Comparative quantification of health risks: Global and regional burden of disease attributable to selected major risk factors. Geneva: World Health Organization: p. 1255–320. PMID
[24] Kirigia et al. (2006). Effects if maternal mortality on GDP in WHO African region. African Journal of Health Services (13): 86-95.
[25] Shonkoff et al. (2012). An integrated scientific framework for child survival and early childhood development. *Pediatrics*, *129*(2), pp.e460-e472.
[26] Victoria, C et al. (2008). Maternal and child undernutrition: consequences for adult health and human capital. *The Lancet* (371): 340-357

Box 1: Assumptions used for the economic analysis

The direct beneficiary population included in the economic analysis are children aged 0-59 months and women in reproductive age (15-49) estimated at 1,021,642 and 1,123,806 in 2021 countrywide, respectively. In line with the project's development objective, it seeks to improve health service delivery to women, children and adolescents in Liberia. Improving health and nutrition outcomes is also expected to facilitate better human capital outcomes. This will be achieved by strengthening the health system to deliver high quality and cost-effective interventions on maternal and child health. The proposed Project is expected to facilitate an increase in the average annual rate of reduction in deaths among women from 1.8 percent over the period 2000-2017 to 4.1 percent during the project implementation period (2021-2026). Among the children below the age of five the proposed Project is expected to facilitate an increase in the average annual rate of reduction from 4.1 percent over the period 1990-2020 to 5.0 percent during the project implementation period (2021-2026). Furthermore, DALYs among the women and children will also be averted.

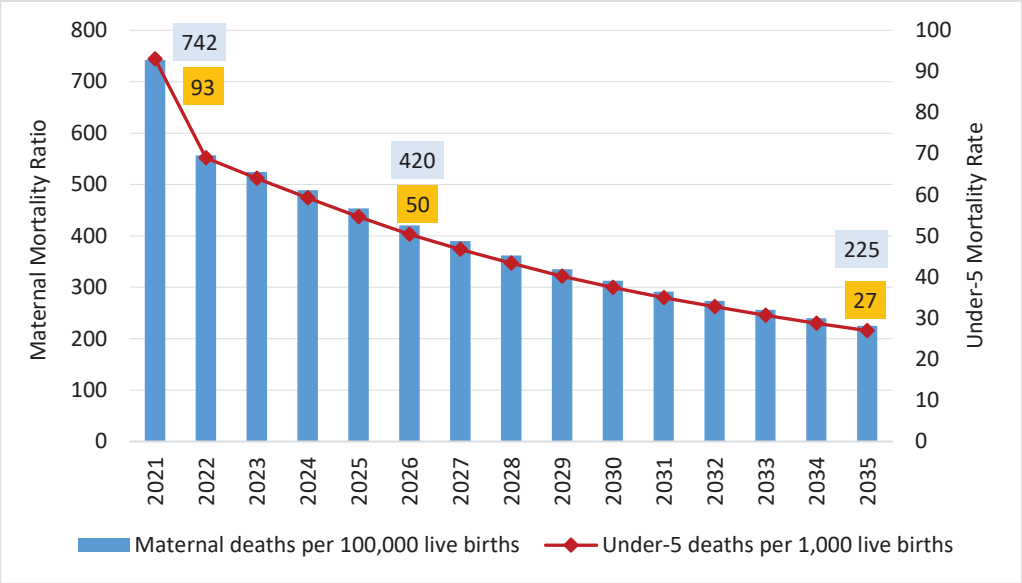
It is assumed that women aged 15-49 will benefit from the proposed Project through income gains from lives saved and increased productivity due to wage losses averted; and reduced or averted expenditures on medical expenses. The children aged 0-59 months will benefit from the program through reduced or averted expenditures on medical expenses. However, full income gains for children are assumed to start accruing after the age of 15. The six-year program implementation period (2021-2026) is extended by 15 years to 2035 given that investments in human development produce long term economic benefit. Further, both the costs and benefits are discounted at a three percent discount rate in line with guidelines from the World Health Organization (Edejer *et al.* 2003. *WHO guide to cost-effectiveness analysis).* To assess whether the calculated cost-effectiveness ratio is worthwhile, opportunity-cost and GDP-based cost-effectiveness thresholds for Liberia are used.

66. **Results from the economic analysis show that the proposed Project is highly cost-effective.** The analysis shows that about 7,132 deaths (471 among mothers and 6,660 among under-5 children) and 675,772 DALYs (40,209 among mothers and 635,563 among under-5 children) will be averted over the period 2021-2035. Subsequently, maternal deaths are expected to reduce from 742 to 225 per 100,000 live births between 2021 and 2035; and under-5 deaths from 93 to 27 per 1,000 live births over the same period (Figure 2). Expressing these results in monetary terms shows that the benefits which will be achieved by implementing the proposed Project are much higher than the estimated cost. At the three percent discount rate, the net present value of benefits and cost are estimated at US$154.1 million and US$75.3 million, respectively; which implies that the benefit to cost ratio is 2:1. This means that for every US$1.0 invested in the proposed Project, the benefit will be US$2.0. Further, the cost-effectiveness ratio (cost per DALY averted) is estimated at US$136 and based on two different thresholds, the conclusion is that the proposed Project is highly cost-effective. In particular, the cost-effectiveness ratio of US$136 per DALY averted under the proposed Project is significantly lower than: (i) the cost-effectiveness threshold for Liberia estimated at US$6.0 to US$234.0 in absolute value and US$11.0 to US$451.0 in purchasing power parity (2013 terms);[27] and (ii) half the US$673.1 GDP per capita (current US$) for Liberia in 2021. The half of GDP per capita cost-effectiveness threshold was referenced in the third edition of the Disease Control Priorities as a criteria for highly resource constrained countries.[28]

[27] Supplementary materials from Woods, B., Revill, P., Sculpher, M. and Claxton, K., 2016. Country-level cost-effectiveness thresholds: initial estimates and the need for further research. *Value in Health*, *19*(8), pp.929-935.

[28] Watkins DA, Jamison DT, Mills A, et al.: Universal health coverage and essential packages of care.In D. T. Jamison, H. Gelband, S. Horton, P. Jha R. Laxminarayan, C. N. Mock and R. Nugent (eds), *Disease control priorities: improving health and reducing*

Figure 2: Expected Reduction in Maternal and Under-5 Mortality



Sensitivity analysis

67. **The assumptions made during the economic analysis assume that there will be favorable government leadership, effective implementation, and no disease outbreaks.** In reality, this may not be the case. To gauge the buoyance of the planned interventions to changes in circumstances and conditions, a sensitivity analysis was conducted. Results from the sensitivity analysis (Table 2) show that the proposed Project will remain viable even if conditions change. The parameters which were used to conduct the sensitivity analysis are: (i) discounting the cost and benefits at higher discount rates of five and 10 percent; (ii) minimizing the project cost by removing the construction of the New Redemption Hospital and assuming a 50 percent funding; and (iii) reducing the project impact by 25 and 50 percent. For all the assumptions, the benefit to cost ratio is higher than one except for the 50 percent reduction in impact where the benefits and cost are even. This demonstrates that the proposed Project is a viable investment.

68. **Notwithstanding the above, it should be noted that the economic analysis did not look at the total gains that will be achieved from implementing all the planned activities under the Project.** Furthermore, the analysis only focused on outcomes for women and under-5 children even though the Project is also expected to impact positively on fathers and other age groups (particularly the adolescents aged 5-24); and diseases and conditions which could be addressed when the health system and service delivery are strengthened. In addition, given the difficulty in accounting for potential benefits from efficiency improvements, these were excluded from the analysis. Therefore, the result of this analysis should be interpreted as an underestimation of the potential benefits from the Project.

poverty. Washington (DC): The International Bank for Reconstruction and Development / The World Bank.2017. 10.1596/978-1-4648-0527-1_ch3

Table 2: Sensitivity Analysis

	Cost per Life Saved (US$)	Cost per DALY averted (US$)	Benefit-Cost Ratio
Parameter 1: Higher discount rate			
3 percent (ideal scenario)	12,855	136	2.0
5 percent	13,410	141	1.9
10 percent	14,545	153	1.7
Parameter 2: Reduced cost			
Status quo	12,855	136	2.0
No funding for the New Redemption Hospital	7,549	80	3.5
No Redemption Hospital and 50 percent funding	3,760	40	7.0
Parameter 3: Reduced impact			
Status quo	12,855	136	2.0
25 percent reduction	12,855	181	1.5
50 percent reduction	12,855	271	1.0

B. Financial Management

69. **FM arrangements will be based on the existing arrangements of the parent Project, carried out by the PFMU.** In addition to the parent Project, the PFMU is now implementing 90 percent of the World Bank and other donor-financed projects in Liberia. It is comprised of 24 staff members. The director and his deputy are both Chartered Accountants, and all PFMU staff are familiar with World Bank procedures. Given that the AF FM arrangements will be based on those of the parent Project, the FM ratings will also apply to the proposed AF. The most recent FM review of the PFMU was conducted in July 2022 and concluded that the control risk is Moderate, and the overall FM risk is Substantial. For the purposes of the parent Project and the AF, the PFMU: (i) updated the current accounting manual; and (ii) customized the existing accounting software to include the account of the AF to generate the Interim Financial Reports (IFRs) and financial statements. The GAC which is currently the external auditor for the parent Project will also audit the AF.

70. **FM arrangements of the parent Project are deemed to be adequate for the proposed AF following an FM assessment.** These arrangements will ensure: (i) timely reporting of project activities; (ii) safeguarding of project assets; and (iii) strengthening of internal controls with reasonable mitigation measures. Therefore, the AF will use the funds flow arrangements in the parent Project. Specifically, the PFMU will produce quarterly unaudited IFRs including, among others, for the Designated Account (DA) and related project accounts. The existing DAs will be closed. A new DA will be opened pooling all sources of funding (Parent, AF-IDA and GFF trust fund). The documentation of the DA will be IFR based. The currency of the DA will be in US$ and the frequency of reporting is quarterly.

71. **The IFRs are to be submitted to the World Bank within 45 days after the end of every quarter.** The format of the IFR will be agreed between the World Bank and the PFMU. The PFMU will prepare the Project's annual accounts/financial statements within three months after the end of the accounting year in accordance with accounting standards acceptable to the World Bank. The audited financial statements and management letter will be submitted to the World Bank within six months after the end of the accounting year. The PFMU will follow the internal control and accountability procedures specified in their FM Manual. The Internal Audit Unit at the PFMU will carry out internal auditing functions of the AF. These

will include coordinating, facilitating, monitoring, and supervising internal audit activities. Currently, the internal auditors do not provide internal audit reports regularly. Under the AF, the PFMU will ensure that internal audit reports are produced regularly and submitted to the World Bank in time.

C. Procurement

72. **Applicable procurement procedures for the AF.** Procurement under the AF will continue to be carried out in accordance with the World Bank's Procurement Regulations for Investment Project Financing Borrowers (Procurement Regulations) dated July 1, 2016 and revised in November 2017, August 2018, November 2020 under the "New Procurement Framework," and the "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants" dated July 1, 2016, and other provisions stipulated in the Financing Agreement. The latest versions of the World Bank's Standard Procurement Documents will be used.

73. **Preparation of the revised Project Procurement Strategy for Development (PPSD).** The MoH has updated the PPSD for the AF. Procurement activities will principally be based on the approved market options, which are in line with the World Bank's Procurement Regulations. The Project actors will leverage the use of Information and Communications Technology to improve participation, delivery, monitoring, and reporting while utilizing the World Bank's Systematic Tracking of Exchanges in Procurement (STEP) as the primary platform to submit, review, and clear all procurement plans. The MoH has experience in implementing World Bank-supported projects but given the additional scope of activities under the AF, the MoH will hire an additional Procurement Officer to complement the work of the two Procurement Officers.

74. **Implementation Arrangements for Procurement.** The proposed AF will be implemented by MoH through the PIU. Currently, the MoH's PIU is headed by a Project Coordinator who manages and coordinates the entire World Bank's Health, Nutrition, and Population portfolio in Liberia which comprises four active projects. The PIU has been performing and delivering satisfactorily. It is proposed that the PIU, with some enhanced capacity, be responsible for managing the AF. The PIU will also require further training on the World Bank's Procurement Regulations, Procurement Framework and the STEP.

75. **The World Bank team conducted a Procurement Capacity and Risk Assessment of the MoH.** The procurement risk is still rated as Substantial. There are limited suppliers of heavy equipment and complex professional services in Liberia. However, the MoH has sound knowledge of the market and has approached the market adequately in previous and ongoing projects. Procurement activities will be based principally on international competition. The PIU will enhance its contract management capacity through training.

D. Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

E. Environmental and Social

76. **Activities under the proposed Project will be carried out in accordance with the World Bank's Environmental and Social Framework.** The new activities supported under the proposed Project are small-scale civil works at existing clinics and procurement and shipment of childhood vaccines. There is no change in implementation arrangement under the proposed Project. Therefore, the ESS identified to be relevant under the proposed AF are: ESS1, ESS2, ESS3, ESS4, ESS8 and ESS10. To address the environmental and social risks and impacts associated with the AF, the existing environmental and social instruments, namely the ESCP and the SEP have been updated and publicly disclosed in-country and the Liberia MoH's website on August 15, 2022.[29] The MoH will also prepare site-specific ESMPs to mitigate environmental and social risks and impacts associated with the small-scale civil works prior to commencement of these activities. The MoH reported that the rehabilitation and extension of infrastructure at existing clinics shall use available land at the targeted clinics. Therefore, no additional land shall be required as the land available for project intervention are encumbrances free and under the MoH. The updated NHCWMP for the parent Project and the National Infection Prevention and Control Guidelines remain relevant for the AF to manage healthcare waste including vaccine-related waste. These documents will be redisclosed before the AF becomes effective.

77. **The Project will consider developing user-friendly infrastructure to accommodate the needs of disabled people.** Further, the existing grievance and feedback mechanism under the parent Project will be enhanced to include: a survivor-centered grievance mechanism for addressing SEA/SH risks; and awareness drives to educate communities and people on medical and hazardous wastes management, use of waste bins, and other waste management processes. The updated GBV action plan shall be used for SEA/SH risks management while the updated SEP shall be used for consultations, engagement and feedback.

F. Gender Consideration

78. **Liberia was ranked 156th out of 162 countries on the Gender Inequality Index in 2019.**[30] As the Liberia CPF for FY19-24 (Report No. 130753-LR, October 26, 2018) articulates, the gender inequality is prevalent in Liberia and contributes to disparities in socio-economic status. Women from poor households and vulnerable communities face severely limited economic, vocational and educational opportunities and endure worse human development outcomes. While a handful of Liberian women have risen to seize top positions in the government, including the former President Ellen Johnson Sirleaf, women in rural areas and poor urban communities have limited access to quality education, healthcare, and employment opportunities. Moreover, adolescent girls in Liberia still experience high rates of early childbearing, early marriages, poor nutrition and dropout from school. Inherited from the prolonged civil war in the 1990s, when rape was used as a weapon against the opponents, Liberia continues to suffer from high incidence of rape and other forms of GBV. The number of reported GBV cases dropped from over 2,000 in 2013 to

[29] Disclosed ESCP: *https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099555008262212420/p17705005f3b9f0a0977b071808b63a27b*
Disclosed SEP: *https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099555108262232006/p17705009536db010ac2f09a4008dff690*
[30] *https://hdr.undp.org/data-center/specific-country-data#/countries/LBR*

approximately 1,400 in 2014, then rose up to over 1,500 in 2015 and 1,700 in 2017 during and after the EVD crisis.[31]

79. **Gender-related actions.** To address the above gender gaps, the Project will support: (i) community outreach programs for preventive and promotive care; (ii) adolescent sexual and reproductive health programs for both in- and out-of-school youths; (iii) expansion of PBF to additional counties and health facilities; (iv) provision of medicines and reproductive health commodities at health facilities, and (v) increased female participation in the health workforce. The revised results framework contains several indicators measuring gender-related actions directly and indirectly. These include: (a) Pregnant women with at least four antenatal care visits; (b) Proportion of new users of modern contraception who are adolescents (10-19 years); (c) Institutional deliveries attended by skilled birth attendants; (d) Number of adolescent girls (10-19 years) counselled for family planning; (e) Out-of-school youths trained in Adolescent Sexual and Reproductive Health; (f) Regular reporting on the implementation of the GBV action plan; and (g) Grievances registered related to delivery of project benefits that are actually addressed.

G. Climate Co-benefit

80. **The Project has been screened for long- and short-term disaster risks and has been found to be highly vulnerable to climate risks, particularly flooding and high temperatures, while risks to the Project's activities are moderate**. Liberia's climate is tropical, hot and humid all year round with a rainy season from May to October and frequent rain in other months except in a short dry season from December to February. Projections show that climate change will increase mean annual temperature from 25.69˚C to 27.35˚C and decrease precipitation from 2467.07 mm to 2371.25 mm by 2020-2059 in comparison to 1991-2020. Liberia is highly reliant on rain-fed agriculture, which is threatened by changes in rainfall and temperatures as well as rainfall variability and erosion. The country is particularly dependent on rice, which is cultivated by 74 percent of the farmers and is highly climate dependent. Changes in rainfall and temperature are also expected to impact the country's main export crops, rubber, cocoa, and coffee, with economic implication. An estimated 40 percent decline in agricultural production in recent years is attributable to increased variability in rainfalls.[32] Liberia's urbanization with high population density in the coastal zones including the capital city Monrovia, escalates the level of vulnerability to climate change as the sea level rises.[33]

81. **Climate change has negative impacts on the delivery of health services and people's health in Liberia.** Chronic malnutrition among children below the age of five estimated at about 30 percent in Liberia,[34] is underlined by food insecurity which is impacted by climate change. During the rainy season roads become difficult to use, especially in the poorest parts of the country.[35] This reduces economic productivity and contributes to seasonal malnutrition due to reduced food distribution.[36] Quality of water in the country is also impacted by climate change hazards and has contributed to the high stunting rates.[37]

[31] Data from the Ministry of Gender, Children and Social Protection
[32] World Bank. 2021. 'Climate Risk Profile: Liberia.' Washington DC: World Bank.
[33] Environmental Protection Agency of Liberia (EPA). 2021. 'Liberia's Second National Communication to the United Nations Framework Convention on Climate Change.' Monrovia: EPA.
[34] Liberia Demographic and Health Survey 2019-2020.
[35] World Bank. 2021. 'Climate Risk Profile: Liberia.' Washington DC: World Bank.
[36] ibid
[37] *https://www.usaid.gov/sites/default/files/documents/1864/Liberia-Nutrition-Profile-Feb2018-508.pdf*

A projected rise in sea level[38] puts Liberia at further risk of flooding and this may continue to negatively impact health. Additionally, Liberia is at risk of vector-borne diseases, including malaria. In 2019, the estimated number of cases per 1,000 people in Liberia was 370 while the number of deaths were 4,587.[39] Similar to other countries in West Africa, malaria in Liberia is negatively associated with average annual temperature and total annual precipitation.[40] Further, extreme flooding can damage health infrastructure and equipment, as well as cause power outages in clinics leading to reduced service provision. On the other hand, extreme temperatures can reduce comfort in health clinics and increase the need for heating and cooling devices. Extreme flooding and temperature can also prevent project staff from undertaking activities in remote areas.

82. **Liberia has climate policies and plans in place, with which the Project is fully aligned, including the National Policy and Response Strategy to Climate Change.[41]** The policy highlights that climate change and hazards increase health risks, including malaria and food insecurity. The policy presents various adaptation strategies which includes education and communication on health risks associated with climate change and strengthening disease surveillance response systems and emergency preparedness. In 2021, Liberia updated its Nationally Determined Contribution (NDC)[42] which outlined increased ambition and commitment to the country's adaptation and mitigation targets in various sectors including health. Through the updated NDC, Liberia is committed to reducing emissions by 64 percent below the projected business-as-usual level by 2030. In addition, Liberia has also delivered its First Adaptation Communication to the United Nations Framework Convention on Climate Change.[43] The other policy documents that Liberia has developed to achieve climate resilience are: the National Disaster Management Policy, the National Energy Policy, and the Food and Agriculture Policy and Strategy. The proposed AF intends to adapt to climate change, aligned with Liberia's existing policies and strategies to enhance climate resilience and adaptation. The activities which will be undertaken under the Project are presented in Table 3.

Table 3: Project Climate Adaptation Activities

Project Component, Subcomponent and Cost	Climate-related action	Activity details and how it will address climate adaptation/mitigation
COMPONENT 2: Improve health service delivery (US$8.00 million AF, IDA)		
Subcomponent 2.2: Improve availability of essential medicines and RMNCAH-N products, routine vaccines, equipment, and logistics (US$8.00 million AF, IDA)	Improved availability of essential medicines, RMNCAH-N products, vaccines and equipment for strengthened health system adaptation	Strengthening the availability of essential medicines will help strengthen the health system's ability to adapt to climate change by: (i) making medications for climate sensitive diseases such as malaria and diarrheal diseases more available; (ii) increasing the availability of pharmaceuticals for people with conditions that are exacerbated by high temperatures such as no-communicable diseases; and (iii) allowing the health system to more effectively maintain operations in the event of a climate shock. **Adaptation**

[38] *https://climateknowledgeportal.worldbank.org/country/liberia/impacts-sea-level-rise*
[39] *https://ourworldindata.org/grapher/incidence-of-malaria-sdgs?tab=chart&country=~LBR*
[40] Arab, A., Jackson, M.C. and Kongoli, C., 2014. Modelling the effects of weather and climate on malaria distributions in West Africa. *Malaria journal*, *13*(1), pp.1-9.
[41] EPA .2018. 'National Policy and Response Strategy on Climate Change.' Monrovia: EPA.
[42] *https://ekmsliberia.info/wp-content/uploads/2021/09/Liberias-Updated-NDC_RL_FINAL-002.pdf*
[43] https://napglobalnetwork.org/resource/liberia-first-adaptation-communication-to-unfccc/

Project Component, Subcomponent and Cost	Climate-related action	Activity details and how it will address climate adaptation/mitigation
	Technical assistance for climate sensitive essential medicine and vaccine distribution planning	This subcomponent will include technical assistance for climate-sensitive vaccine distribution to place adequate quantities of supplies in accessible locations ahead of anticipated flooding, in the context of impassable roads during flooding in Liberia. **Adaptation**
COMPONENT 3: Strategic purchasing and equity in health financing (US$10.50 million AF, IDA)		
Subcomponent 3.1: Expand coverage of PBF (US$10.00 million AF, IDA)	PBF for strengthened health system coverage and quality, improving climate adaptation	Strengthened health service coverage and quality will help the health system more effectively adapt to the impacts of climate change by: (i) increasing the number of people who have access to health services, improving the health of the population before climate shocks and access to health services in the event of climate shocks; (ii) improving the quality of the services provided, improving population health prior to and in the event of climate shocks; (iii) improving the coverage and quality of services for climate-sensitive for climate sensitive conditions such as malnutrition and malaria; and (iv) improving access to health services for people with health conditions, such as NCDs, that are exacerbated in climate shocks, particularly high temperatures. **Adaptation**
	Primary level PBF for climate-sensitive conditions and climate shocks	Liberia's primary level PBF program includes measures for the following areas which are directly climate related: (i) Malaria (16 points), which is climate-sensitive in Liberia's context; (ii) Nutrition (17 points), which is also climate-sensitive in Liberia's context ; (iii) Tuberculosis (18 points), whose incidence is increased with rising temperatures based on biologic and global research[44]; (iv) Laboratory (13 points), including diagnostics of climate-sensitive diseases such as malaria, diarrheal diseases, and tuberculosis; (v) management of essential medicines (12 points) and availability of pharmaceuticals (17 points), which includes medicines for climate sensitive diseases such as malaria and diarrheal diseases and will also help the health system to effectively adapt to the impacts of climate change; (vi) infection prevention and control including water and sanitation (29 points) which will help prevent the spread of infectious disease in case of climate shocks; and (vii) community PBF (20 points) which will strengthen community health systems and strengthen climate change adaptation. In total, these climate-related measures account for 39 percent of the primary-level PBF program (144/373 points). **Adaptation**
	Hospital level PBF for climate-sensitive conditions and climate shocks	Liberia's hospital level PBF program includes measures for the following areas which are directly climate related. The climate links with each of these areas are the same as for primary level PBF, as described above: (i) Malaria (16 points);

[44] *https://www.nature.com/articles/s41558-022-01284-x.epdf?sharing_token=DSGReaBPMkXoXetkf0jKPNRgN0jAjWel9jnR3ZoTv0PFwMZzlzMH8X2V_lztCkyVeSFRqOALB60A0I_QzzP0N3SxzfiX0j0kDCjSzXH1DwFIXh7QZB4QsWMw6jjqRrrlkVQ19V92upE2St5x15ZvzrkyjkufoOZ49O069U7dX-4%3D*

Project Component, Subcomponent and Cost	Climate-related action	Activity details and how it will address climate adaptation/mitigation
		(ii) Infection prevention and control including water and sanitation (29 points); (iii) Nutrition (18 points); (iv) Tuberculosis (17 points); (v) Laboratory (20 points); Management of essential medicines (15 points); and availability of pharmaceuticals (19.5 points). In total, these climate-related measures account for 36 percent of the hospital-level PBF program (134.5/377.5 points). **Adaptation**
	PBF for climate emergency preparedness and response	A climate adaptation measure will be included in both the primary and secondary level PBF programs. While the exact definition of the measure is to be identified, this is expected to assess the availability of climate emergency preparedness and response plans at primary level facilities and hospitals to improve the adaptation of facilities to climate shocks. **Adaptation**
COMPONENT 4: Project management, and monitoring and evaluation (US$1.50 million AF, IDA)		
Subcomponent 4.1: Project coordination and support to implementing units (US$1.50 million AF, IDA)	Monitoring of the Project's climate activities	This subcomponent will monitor the Project's climate activities and as such, it should be assessed at the same rate as the climate activities in the Project. **Adaptation**

V. WORLD BANK GRIEVANCE REDRESS

83. Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level GRMs or the World Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the World Bank's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of World Bank non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and World Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate GRS, please visit *http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service*. For information on how to submit complaints to the World Bank Inspection Panel, please visit *www.inspectionpanel.org*.

VI SUMMARY TABLE OF CHANGES

	Changed	Not Changed
Results Framework	✓	
Components and Cost	✓	
Reallocation between Disbursement Categories	✓	
Disbursements Arrangements	✓	
Implementing Agency		✓
Project's Development Objectives		✓
Loan Closing Date(s)		✓
Cancellations Proposed		✓
Legal Covenants		✓
Institutional Arrangements		✓
Financial Management		✓
Procurement		✓
Implementation Schedule		✓
Other Change(s)		✓

VII DETAILED CHANGE(S)

COMPONENTS

Current Component Name	Current Cost (US$, millions)	Action	Proposed Component Name	Proposed Cost (US$, millions)
Component 1: Improved service delivery	68,000,000.00	Revised	Component 1: Improve health infrastructure	38,000,000.00
Component 2: Institutional strengthening to address key binding constraints	11,000,000.00	Revised	Component 2: Improve health service delivery	23,000,000.00
Component 3: Project Management	5,000,000.00	Revised	Component 3: Strategic purchasing and equity in health financing	18,500,000.00

Component 4: Contigency Emergency Response Component	0.00	Revised	Component 4: Project management, and monitoring and evaluation	5,500,000.00
	0.00	New	Component 5: Contingency Emergency Response	0.00
TOTAL	**84,000,000.00**			**85,000,000.00**

REALLOCATION BETWEEN DISBURSEMENT CATEGORIES

Current Allocation	Actuals + Committed	Proposed Allocation	Financing % (Type Total)	
			Current	Proposed
IDA-66460-001 | Currency: USD				
iLap Category Sequence No: 1	Current Expenditure Category: GD,WK,NCS,CS,OC,TR under Part A (except under Part A.3(b)) of the Project			
44,865,000.00	642,753.61	646,400.00	100.00	100.00
iLap Category Sequence No: 2	Current Expenditure Category: PBF Grants under Part A.3(b) of the Project			
2,000,000.00	1,427,200.05	1,427,300.00	100.00	100.00
iLap Category Sequence No: 3	Current Expenditure Category: Eligible Expenditure Program (EEP) under Part B of the Project			
6,000,000.00	0.00	0.00	100.00	100.00
iLap Category Sequence No: 4	Current Expenditure Category: GD,WK,NCS,CS,OC,TR under Part C of the Project			
1,000,000.00	225,793.67	225,800.00	100.00	100.00
iLap Category Sequence No: 5	Current Expenditure Category: GD,WK,NCS,CS,OC,TR under Part A of the Project			
0.00	0.00	37,864,600.00	0.00	100.00
iLap Category Sequence No: FEF	Current Expenditure Category: FRONT END FEE			
135,000.00	135,000.00	135,000.00		

iLap Category Sequence No:		Current Expenditure Category: GD,WK,NCS,CS,OC,TR under Parts B.1 and B.3 of the Project			
0.00	0.00	5,854,000.00		100.00	
iLap Category Sequence No:		Current Expenditure Category: GD,WK,NCS,CS,OC,TR under Part B2 of the Project			
0.00	0.00	4,500,000.00		100.00	
iLap Category Sequence No:		Current Expenditure Category: GD,WK,NCS,CS,OC,TR under Parts C.1 (a) (c) and (d), and D.1 of the Project			
0.00	0.00	1,774,200.00		100.00	
iLap Category Sequence No:		Current Expenditure Category: PBF Grants under Part C.1(b) of the Project			
0.00	0.00	1,572,700.00		100.00	
iLap Category Sequence No:		Current Expenditure Category: Emergency Expenditures under Part E of the Project			
0.00	0.00	0.00		100.00	
iLap Category Sequence No:		Current Expenditure Category: Interest Rate Cap or Interest Rate Collar premium			
0.00	0.00	0.00		100.00	
Total	**54,000,000.00**	**2,430,747.33**	**54,000,000.00**		

DISBURSEMENT ARRANGEMENTS

Change in Disbursement Arrangements

Yes

Expected Disbursements (in US$)

Fiscal Year	Annual	Cumulative
2020	0.00	0.00
2021	2,035,990.00	2,035,990.00
2022	2,175,000.00	4,210,990.00

2023	22,500,000.00	26,710,990.00
2024	25,600,000.00	52,310,990.00
2025	17,315,017.00	69,626,007.00
2026	15,373,993.00	85,000,000.00
2027	0.00	85,000,000.00

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Latest ISR Rating	Current Rating
Political and Governance	Substantial	Substantial
Macroeconomic	Substantial	Substantial
Sector Strategies and Policies	Moderate	Moderate
Technical Design of Project or Program	Substantial	Substantial
Institutional Capacity for Implementation and Sustainability	Substantial	Substantial
Fiduciary	Substantial	Substantial
Environment and Social	Moderate	Moderate
Stakeholders	Low	Low
Other		
Overall	Substantial	Substantial

LEGAL COVENANTS – Additional Financing for Institutional Foundations to Improve Services for Health (P177050)

Sections and Description
ESS5: RAP Implementation Completion Report for the RAP implemented for clearing and acquisition of the land required for redemption hospital and obtain NO from Association - No later than 90 days of the project effectiveness
ESS10: Strengthen the grievance mechanism established under the Original Project and form new grievance redressal committees, where required, as part of the Project GM within 30 days of the Effective Date and thereafter maintain and operate the GM throughout Project implementation.
Capacity Support from ESCP: Prepare a training guide and provide training for PIU staff, stakeholders, communities, Project workers on the following: GBV & SEA/SH; GBV Code of Conduct for project workers; Community health and safety; Healthcare waste management for health facilities; GRM Standard Operating Procedures (SOP) for committee members (roles

and responsibilities) - Within one month of the Effective Date and conduct at least one training session each six months, throughout Project implementation.

Conditions

Type	Financing source	Description
Effectiveness	Trust Funds, IBRD/IDA	The Recipient has updated, adopted and submitted to the Association, the Project Implementation Manual, in form and substance satisfactory to the Association
Effectiveness	Trust Funds, IBRD/IDA	The Recipient has disclosed and adopted the National Healthcare Waste Management Plan (NHCWMP) and the National Infection Prevention and Control (IPC) Guidelines, all in form and substance satisfactory to the Association
Effectiveness	Trust Funds, IBRD/IDA	The Recipient has disclosed and adopted the Labor Management Procedures (LMP), in form and substance satisfactory to the Association
Effectiveness	Trust Funds, IBRD/IDA	The Recipient has prepared, consulted upon, approved, disclosed and adopted the GBV, SEA/SH Action Plan, in form and substance satisfactory to the Association
Disbursement	Trust Funds, IBRD/IDA	No withdrawal shall be made under Category (3) unless the Recipient has furnished evidence satisfactory to the Association that: (i) a PBF Verification Agent with qualifications and experience and under terms of reference satisfactory to the Association has been recruited; and (ii) the appropriate mechanisms for verification of PBF related results have been established in accordance with the PIM.
Disbursement	IBRD/IDA	No withdrawal shall be made under Category (5) for Emergency Expenditures unless: (i) (A) the Recipient has determined that an Eligible Crisis or Emergency has occurred, and has furnished to the Association a request to withdraw Financing amounts under Category (4); and (B) the Association has agreed with such determination, accepted said request and notified the Recipient thereof; (ii) the Recipient has adopted the CERC Manual and Emergency Action Plan, in form and substance acceptable to the Association; and (iii) the Recipient has prepared,

		and adopted the CERC Manual and Emergency Action Plan, in form and substance acceptable to the Association
Type Effectiveness	Financing source Trust Funds	Description The GFF Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled

VIII. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: Liberia

Additional Financing for Institutional Foundations to Improve Services for Health

Project Development Objective(s)

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

Project Development Objective Indicators by Objectives/ Outcomes

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
To improve health services to women, children and adolescents in Liberia								
Redemption Hospital completed and operational (Number)		0.00	0.00	0.00	0.00	0.00	0.00	1.00
Action: This indicator has been Revised								
Pregnant women with at least 4 antenatal care visits (Percentage)		32.00	35.00	44.00	45.00	48.00	50.00	55.00
Action: This indicator has been Revised								
Proportion of new users of modern contraception who are adolescents (10-19 years) (Percentage)		37.00	39.00	42.00	45.00	48.00	50.00	53.00

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Action: This indicator has been Revised								
Institutional deliveries attended by skilled birth attendants (Percentage)		54.00	57.00	62.00	65.00	68.00	72.00	75.00
Action: This indicator has been Revised								
Adolescent girls aged 10-19 counselled on family planning (Number)		34,634.00	34,725.00	35,980.00	37,235.00	38,490.00	39,745.00	41,000.00
Action: This indicator has been Revised								
Proportion of children under one year fully immunized (Percentage)		64.00	67.00	70.00	72.00	75.00	77.00	80.00
Action: This indicator is New								

Intermediate Results Indicators by Components

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Component 1: Improve health infrastructure *(Action: This Component has been Revised)*								
Redemption Hospital constructed (Yes/No)		No	No	No	No	Yes	Yes	Yes
Action: This indicator has been Revised								

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Redemption Hospital fully equipped (Yes/No)		No	No	No	No	No	Yes	Yes
Action: This indicator has been Revised								
Redemption Hospital operational (Yes/No)		No	No	No	No	No	No	Yes
Action: This indicator has been Revised								
New Redemption Hospital Investment Plan developed (Yes/No)		No	No	No	Yes	Yes	Yes	Yes
Action: This indicator has been Revised								
Primary health facilities in project areas refurbished and equipped (cumulative) (Number)		0.00	0.00	0.00	5.00	15.00	20.00	20.00
Action: This indicator has been Revised								
Redemption Hospital Phase 2 - Fully Equipped (Date)		03-Aug-2020						30-Apr-2026
Action: This indicator has been Marked for Deletion								
Redemption Hospital Phase 2 - Operational (Date)		03-Aug-2020						31-Aug-2026
Action: This indicator has been Marked for Deletion								
Health facilities certified (quality) to provide maternal, newborn, child and adolescent health		0.00	20.00	40.00	60.00	80.00		100.00

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
services (Percentage)								
Action: This indicator has been Marked for Deletion								
Component 2: Improve health service delivery *(Action: This Component has been Revised)*								
Routine household visits conducted by Community Health Assistants (CHAs) in selected counties (Number)		237,631.00	240,000.00	245,000.00	250,000.00	296,109.00	304,993.00	314,142.00
Action: This indicator is New								
Out of school youths trained in Adolescent Sexual and Reproductive Health (ASRH) (Number)		0.00	0.00	0.00	150.00	350.00	500.00	750.00
Action: This indicator has been Revised								
Regular reporting on the implementation of the Gender Based Violence (GBV) (Yes/No)		No	No	No	Yes	Yes	Yes	Yes
Action: This indicator is New								
Grievances registered related to delivery of project benefits that are actually addressed (Percentage)		61.70	62.50	65.00	68.00	70.00	75.00	80.00
Action: This indicator has been Revised								

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Availability of tracer drugs and medical supplies (as per defined list) in project areas (Percentage)		0.00	7.00	10.00	15.00	20.00	25.00	35.00
Action: This indicator has been Revised								
Annual increase in government budget for childhood vaccination (Percentage)		0.00	0.00	0.00	30.00	50.00	75.00	80.00
Action: This indicator is New								
Health professional trained in specialized courses (six months and above) (cumulative) (Number)		0.00	0.00	0.00	30.00	40.00	50.00	60.00
Action: This indicator is New								
Skills labs upgraded and equipped at selected training institutions (cumulative) (Number)		0.00	0.00	0.00	2.00	3.00	4.00	5.00
Action: This indicator is New								
Develop staffing norms in line with the Essential Package of Health Services (Yes/No)		No	No	No	No	Yes	Yes	Yes
Action: This indicator is New								

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Number of complete and timely monthly narrative reports available (per hospital) from 25 identified Hospitals/Health Centers providing cesarean section services (Number)		0.00	10.00	10.00	10.00	10.00		12.00
Action: This indicator has been Marked for Deletion								
Annual report available from HR database reporting recruitment, transfers, and disciplinary action taken during previous year (Yes/No)		No	Yes	Yes	Yes	Yes		Yes
Action: This indicator has been Marked for Deletion								
Component 3: Strategic purchasing and equity in health financing *(Action: This Component has been Revised)*								
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		539,995.00	478,645.00	550,644.00	631,644.00	712,643.00	757,642.00	809,993.00
Action: This indicator has been Revised								
People who have received essential HNP services - Female (Number)		411,164.00	360,009.00	428,296.00	479,691.00	513,955.00	548,219.00	616,746.00

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Action: This indicator is New								
Number of women and children who have received basic nutrition services (Number)		23,796.00	84,713.00	90,643.00	96,988.00	103,777.00	111,042.00	118,815.00
Action: This indicator is New								
Number of deliveries attended by skilled health personnel (CRI, Number)		16,695.00	17,922.00	18,818.00	19,759.00	20,747.00	21,784.00	22,874.00
Action: This indicator has been Revised								
Clinics implementing PBF with a minimum quality score of 70 percent (Percentage)		40.00	40.00	40.00	55.00	60.00	70.00	80.00
Action: This indicator is New								
Hospitals implementing PBF with a minimum quality score of 75 percent (Percentage)		40.00	40.00	40.00	60.00	70.00	75.00	80.00
Action: This indicator is New								
PBF clinics with functional health facility development committees (HFDCs) with citizen representation (Percentage)		0.00	30.00	40.00	70.00	80.00	100.00	100.00

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
Action: This indicator is New								
Timely and accurate verification conducted by the National Verification Agency (NVA) (Yes/No)		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Action: This indicator is New								
Reports on health financing and system strengthening (cumulative) (Number)		0.00	0.00	0.00	1.00	2.00	3.00	3.00
Action: This indicator is New								
Regular reporting on GBV action plan implementation (any changes in the GBV action plan will be notified to the Bank and recorded) (Yes/No)		No	Yes	Yes	Yes	Yes		Yes
Action: This indicator has been Marked for Deletion								
Component 4: Project management, and monitoring and evaluation *(Action: This Component is New)*								
MoH maintains essential PIU staff in key positions throughout project implementation (Yes/No)		Yes	Yes	Yes	Yes	Yes	Yes	Yes
Action: This indicator has been Revised								
Monitoring visits conducted annually by the PIU		0.00	4.00	4.00	4.00	4.00	4.00	4.00

Indicator Name	PBC	Baseline	Intermediate Targets					End Target
			1	2	3	4	5	
(Number)								
Action: This indicator has been Revised								
Country platform meetings held to discuss key RMNCAH-N indicators (Number)		0.00	2.00	2.00	2.00	2.00	2.00	2.00
Action: This indicator has been Revised								
Maternal and perinatal death surveillance and response (MPDSR) reviews undertaken each year (Number)		0.00	0.00	0.00	4.00	4.00	4.00	4.00
Action: This indicator is New								
Technical support visits conducted by the family health division (Number)		0.00	1.00	2.00	4.00	4.00	4.00	4.00
Action: This indicator is New								

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Redemption Hospital completed and operational	This indicator monitors the construction, equipping	Annual	Project report	Visual inspection and supervision by the MoH	MoH/PIU

	and operationalization of the New Redemption Hospital			infrastructure unit and PIU	
Pregnant women with at least 4 antenatal care visits	Numerator: Number of pregnant women having four or more antenatal care visits; Denominator: Estimated number of pregnancies	Annual	DHIS-2	Generate data from routine health information system	MoH/HMER
Proportion of new users of modern contraception who are adolescents (10-19 years)	Numerator: Number of new acceptors of modern contraceptive aged 10-19; Denominator: Total new acceptors (all ages) of modern contraceptive	Annual	DHIS-2	Generate data from routine health information system	MoH/HMER
Institutional deliveries attended by skilled birth attendants	Numerator: Number of deliveries conducted in health facilities by a medical doctor, nurse, physician assistant, physician, certified or registered midwife during a specified reporting period; Denominator: Estimated number of deliveries at the health facilities during a specified reporting period	Annual	DHIS-2	Generate data from routine health information system	MoH/HMER
Adolescent girls aged 10-19 counselled on family planning	This indicator measures the number of adolescent girls aged 10-19 years who have received at least one counselling session on	Annual	DHIS-2	Generate data from routine health information system	MoH/HMER

	family planning in the project areas				
Proportion of children under one year fully immunized	Measures the proportion of children below one year who have received all the recommended vaccines at that age. Numerator: Total number of children under one year fully immunized; Denominator: Expected number of under one year children	Annual	DHIS-2	Generate data from routine health information system	MoH/HMER

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Redemption Hospital constructed	This indicator monitors the construction of the New Redemption Hospital	Annual	Project report	Visual inspection and supervision by the MoH infrastructure unit and PIU	MoH/PIU
Redemption Hospital fully equipped	This indicator monitors progress on installation of equipment at the New Redemption Hospital	Annual	Project report	Visual inspection and supervision by the MoH infrastructure unit and PIU	MoH/PIU
Redemption Hospital operational	This indicator monitors progress on the operationalization of the New Redemption Hospital	Annual	Project report	Visual inspection and supervision by the MoH infrastructure unit and PIU	MoH/PIU

New Redemption Hospital Investment Plan developed	This indicator monitors short- to long-term commitment by government to maintain operations at the New Redemption Hospital	Annual	Project report	Needs and budget analysis	MoH/PIU
Primary health facilities in project areas refurbished and equipped (cumulative)	This indicator measures the cumulative number of primary health facilities refurbished and equipped in project areas. Annual achievement is added to the previous year's number	Annual	Project report	Visual inspection and supervision by the MoH infrastructure unit and PIU	MoH/PIU
Redemption Hospital Phase 2 - Fully Equipped		Quarterly	MOH project monitoring report	Visual inspection and supervision by the MOH infrastructure unit and PIU	MOH and PIU
Redemption Hospital Phase 2 - Operational		Quarterly	MOH project monitoring report	Visual inspection and supervision by the MOH infrastructure unit and PIU	MOU and PIU
Health facilities certified (quality) to provide maternal, newborn, child and adolescent health services	The proportion of the 25 target hospitals/HCs certified as having attained a specific level of quality based on a pre-defined, standardized protocol.	Quarterly	MOH	Site visits	MOH/PIU

Routine household visits conducted by Community Health Assistants (CHAs) in selected counties	Measures the number of household visits conducted by CHAs in selected counties during the period under review	Annual	Project report	Monitoring and supervision visits	MoH/PIU
Out of school youths trained in Adolescent Sexual and Reproductive Health (ASRH)	Measures the number of out of school youths trained in ASRH during the period under review. The number trained each year is added to the previous year's number	Annual	Project report	Monitoring and evaluation visits	MoH/PIU
Regular reporting on the implementation of the Gender Based Violence (GBV)	This indicator monitors progress on the implementation of the GBV action plan	Annual	Project report	Monitoring and supervision visits	MoH/PIU
Grievances registered related to delivery of project benefits that are actually addressed	This indicator measures the functionality of the grievance redress mechanism under the project. Numerator: Total number of cases/complaints addressed; Denominator: Total number of cases/complaints formally reported	Annual	Project report	Monitoring and supervision visits	MoH/PIU
Availability of tracer drugs and medical supplies (as per defined list) in project areas	This indicator measures the proportion of public health facilities in project areas with	Annual	eLMIS	Generate data from the eLIMS	MoH/PIU

	no stock out of EVEN ONE tracer drug [0 day of stock out] during the period under review. Numerator: Number of public health facilities in project areas with no stock out of tracer drugs [0 day of stock out] during the period under review Denominator: Total number of public health facilities in the project area				
Annual increase in government budget for childhood vaccination	This indicator monitors the annual percentage increase in the government allocation for childhood vaccines. Measurement: (Current year budget minus 2022 budget) / 2022 budget) X 100	Annual	Project report	Analysis of annual budget for childhood vaccines	MoH/PIU/PFMU
Health professional trained in specialized courses (six months and above) (cumulative)	This indicator measures the cumulative number of health personnel receiving training of more than six months in specialized courses in pediatric, obstetric, and gynecology through the project each year	Annual	Project report	Review of project implementation data	MoH/PIU

Skills labs upgraded and equipped at selected training institutions (cumulative)	This indicator monitors progress on the upgrading and equipping of skills labs at identified training institutions. The number upgraded and equipped each year is added to the previous year's number	Annual	Project report	Review of project implementation data	MoH/PIU
Develop staffing norms in line with the Essential Package of Health Services	This indicator monitors the development of staffing norms in accordance with the Essential Package of Health Services	Annual	Project report	Review of project implementation data	MoH/PIU
Number of complete and timely monthly narrative reports available (per hospital) from 25 identified Hospitals/Health Centers providing cesarean section services	Numerator - Number of months for which all required HIS reports from the specified Hospitals/Health centers were submitted; Denominator - Total number of months for which HIS reports from specified Hospitals/ Health centers were required	Monthly	HIS subsystems report rate summary	Health facility reports	MOH/IVA
Annual report available from HR database reporting recruitment, transfers, and disciplinary action taken during previous year	Number of verifiable criteria satisfied by the HRH department annual report	Annual	HRH annual report	Generate data from routine health information system	HMER/IVA
People who have received essential health, nutrition, and population (HNP) services		Annual	DHIS-2	Generate data from routine health information system	MoH/HMER

People who have received essential HNP services - Female	This indicator is a subset of the main indicator. While the main indicator tracks the total number of outpatients visits or consultations at primary health facilities and hospitals in project areas; this indicator focuses on the total number of outpatient visits or consultations for females.	Annual	DHIS-2	Generate data from routine health information system	MoH/HMER
Number of women and children who have received basic nutrition services	This indicator tracks the total number of women who have received iron/folate and the total number of under-5 children who have received Vitamin A. It is the sum of the number for women and under-5 children.	Annual	DHIS-2	Generate data from routine health information system	MoH/HMER
Number of deliveries attended by skilled health personnel		Annual	DHIS-2	Generate data from routine health information system	MoH/HMER
Clinics implementing PBF with a minimum quality score of 70 percent	Numerator: Number of clinics implementing PBF in project areas with a PBF quality score of at least 70%; Denominator: Total number of clinics	Annual	Project report	Review of PBF verification data	MoH/PIU

	implementing PBF in project areas				
Hospitals implementing PBF with a minimum quality score of 75 percent	Numerator: Number of hospitals implementing PBF in project areas with a PBF quality score of at least 75%; Denominator: Total number of hospitals implementing PBF in project areas	Annual	Project report	Review of PBF verification data	MoH/PIU
PBF clinics with functional health facility development committees (HFDCs) with citizen representation	Numerator: Number of clinics implementing PBF in project areas with functional HFDCs; Denominator: Total number of clinics implementing PBF in project areas	Annual	Project report	Review of minutes of health center committee meetings and action taken reports	MoH/PIU
Timely and accurate verification conducted by the National Verification Agency (NVA)	This indicator monitors the timeliness of submitting verification reports by the NVA and accuracy of the submitted data	Annual	Project report	Review of PBF verification data	MoH/PIU
Reports on health financing and system strengthening (cumulative)	This indicator tracks the number of reports on health financing and system strengthening in support of the establishment of the Liberia Health Equity Fund, produced through direct	Annual	Project report	Review of project implementation data	MoH/PIU

	and parallel-financed World Bank studies during the project implementation period. The number of reports produced each year is added to the previous year's number				
Regular reporting on GBV action plan implementation (any changes in the GBV action plan will be notified to the Bank and recorded)	This indicator monitors that the PIU will report regularly on the GBV action plan.	6-Monthly	Project monitoring report	Project report	PIU
MoH maintains essential PIU staff in key positions throughout project implementation	This indicator monitors the availability of essential PIU staff at all times during project implementation. These are: Project coordinator, financial management officer, procurement officer, environment and social officer, monitoring and evaluation officer, and PBF Technical Assistant	Annual	Project report	Review of staff returns	MoH/PIU
Monitoring visits conducted annually by the PIU	This indicator monitors the implementation of project activities including the NVA	Annual	Project report	Review of project implementation data	MoH/PIU
Country platform meetings held to discuss key RMNCAH-N indicators	This indicator tracks the number of country platform meetings conducted annually where key RMNCAH-N indicators are discussed and minutes	Annual	Project report	Review of minutes of the meetings and action taken reports	MoH/PIU

	available				
Maternal and perinatal death surveillance and response (MPDSR) reviews undertaken each year	This indicator measures the number of comprehensive national MPDSR reviews conducted to analyze data collected from counties and to identify actions to be taken for quality improvement in respective counties	Annual	Project report	Review of project implementation data	MoH/PIU
Technical support visits conducted by the family health division	This indicator assesses the number of technical support visits conducted annually by the family health division	Annual	Project report	Review of data from the family health division at the MoH	MoH/PIU