



The World Bank

Institutional Foundations to Improve Services For Health (P169641)

Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 16-Apr-2019 | Report No: PIDC26573



BASIC INFORMATION

A. Basic Project Data

Country Liberia	Project ID P169641	Parent Project ID (if any)	Project Name Institutional Foundations to Improve Services For Health (P169641)
Region AFRICA	Estimated Appraisal Date Oct 14, 2019	Estimated Board Date Feb 27, 2020	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) Republic of Liberia	Implementing Agency Ministry of Health	

Proposed Development Objective(s)

Strengthening institutional management for enhanced health services to women, children and adolescents in Liberia.

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	40.00
Total Financing	40.00
of which IBRD/IDA	40.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	40.00
IDA Credit	40.00

Environmental and Social Risk Classification

Moderate

Concept Review Decision

Track II-The review did authorize the preparation to continue



The World Bank

Institutional Foundations to Improve Services For Health (P169641)



Other Decision (as needed)

B. Introduction and Context

Country Context

The Human Capital Index for Liberia is 0.32, ranking 154 of 157 countries. The Human Capital Index (HCI)¹ which, has been constructed for 157 countries, measures the amount of human capital that a child born today can expect to attain by age 18, and is 0.32 for the country. The index infers the productivity of the next generation of the population compared to a benchmark of complete education and full health. This implies that a child born in Liberia today will be 32 percent as productive when s/he grows up as s/he could be if s/he enjoyed complete education and full health.²

Liberia is among the world's poorest countries. With a gross national income (GNI) per capita of US\$370 in 2016,³ Liberia is a fragile state striving to overcome the legacy of two devastating civil wars (1989–1997; and 1999–2003), which severely disrupted the economy and inflicted an especially devastating toll on the poor. The Gross Domestic Product (GDP) grew by 2.5 percent in 2017; however, revised projections point to growth of 1.2 percent in 2018 and 0.4 percent in 2019, according to the latest figures (March 9, 2019) from the International Monetary Fund (IMF). One-quarter of the country's 4.5 million people lives in the capital city, Monrovia, and in surrounding Montserrado County. The remaining 3.4 million people live in the other 14 counties. Liberia's global rank in Transparency International's Corruption Perceptions Index fell from 75th out of 174 countries in 2012 to 90th in 2016, then plunged to 122nd in 2017—the largest single-year drop in Africa. Liberia, as a fragile post-conflict state, receives significant inflows of development assistance,⁴ but leveraging external support to create a foundation for sustainable and inclusive growth poses a persistent challenge. Fragility is both a cause and consequence of poor Human Capital outcomes.

Liberia's institutions and organizational capacity were severely eroded through the period of the civil war, and just as it was recovering, the Ebola Virus Disease (EVD) outbreak struck. The health sector in the country was particularly affected as it lost an invaluable mass of its skilled human resource asset base. At the same time the capacity and organizational ability of the institutions essential for enabling an effective and efficient health system to function was severely depleted. This weak institutional base is reflected in an inadequate health workforce, with no clearly defined career path or incentives to work in the system and with little accountability and transparency; and dysfunctional management and organizational systems that hinder timely and affordable drugs and services availability to the sick and needy.

Poverty, urban-rural and gender disparities significantly impact the human capital. Poverty in Liberia is widespread, and while poor households are heavily concentrated in rural areas, urban poverty also poses a significant challenge.⁵ Non-monetary poverty indicators such as access to healthcare (described in the next Section), education, and public services are marked by acute rural-urban and gender disparities. Among wealthier households and households in urban areas, 48 percent of children between the ages of 6 and 11 attend primary school, compared to just 26 percent of children from poorer households and households in rural areas. Early marriage and childbearing, especially in rural areas, widen gender gaps in education, and poor households often focus their limited resources on educating boys. Early childbearing is associated with young women dropping out of school, with lasting negative impacts on their skills and economic empowerment. Women from poor households and vulnerable communities face severely limited economic opportunities and endure worse human development outcomes. Liberian women experience high rates of early pregnancy, school dropout, and child and maternal mortality, all of which are especially common among poor households.



Sectoral and Institutional Context

While Liberia made significant progress in health service delivery, after the civil wars and till 2013, the EBV outbreak (2014-16) reversed some of the previous gains and constrained the health system's functionality. Between 1986 and 2013, the country's under-five mortality rate and its infant mortality rate declined from 220 deaths to 94 deaths per 1,000 live births and from 144 deaths to 54 deaths per 1,000 live births, respectively. Moreover, health and service-delivery indicators improved between 2000 and 2013: the measles immunization coverage increased from 52 percent to 74.2 percent; the prevalence of stunting among children under five years old declined from 39 percent in 2007 to 32 percent in 2013;¹ and life expectancy at birth increased from 52 years to 61 years. The EVD crisis reversed some of these achievements: deliveries by skilled birth attendants fell by 7 percent, fourth antenatal care visits dropped by 8 percent, the measles coverage rate declined by 21 percent, and health-facility utilization rates plummeted by 40 percent. The country also lost a staggering 10 percent of its doctors and 8 percent of its nurses and midwives to the EVD—over 8 percent of the nation's health workforce. A 2015 study estimated that the deaths of these workers could potentially increase the maternal mortality rate by 111 percent relative to the pre-EVD baseline. Liberia's maternal mortality rate at 1,072 deaths for every 100,000 pregnancies (i.e., 1 death for every 93 women) is among the highest in the world. Despite a decline in the stunting rate, Liberia still has the sixth- and eighth-highest stunting rates in West Africa for male and female children, respectively. Adequate nutrition, particularly in the first five years of a child's life, is vital to physical, social, and cognitive development; and to a child's readiness to learn and is linked to better educational and economic outcomes.

While funding to the health sector has increased in recent years, it remains insufficient to provide basic health services to the population and make sustained progress on health outcomes. The Government of Liberia (GOL) has prioritized the health sector over time: General Government Health Expenditure (GGHE) as a percentage of general government expenditure increased from 7 percent in 2000 to 12 percent in 2014,⁶ before reaching 14.6 percent for the 2017/18 fiscal year.⁷ However, given the relative small size of the total government budget, the increase of the GGHE is not enough to respond to the significant needs in the health sector, the poorest population bearing the brunt: 15% of poor households encountered catastrophic health expenditures compared to 8% among the rich⁸. Outpatient services⁹ and over-the-

¹ HCI is made up of five indicators (including data for Liberia): the probability of survival to age five (93 out of 100 children born in Liberia survive to age 5); a child's expected years of schooling (a child who starts school at age 4 can expect to complete 4.4 years of school by her 18th birthday (and 2.3 is the learning-adjusted years of school)); harmonized test scores as a measure of quality of learning (332 on a scale where 625 represents advanced attainment and 300 represents minimum attainment), adult survival rate (fraction of 15-year olds that will survive to age 60 -77%); and the proportion of children who are not stunted (68 out of 100 children, and therefore 32 out of 100 children are at risk of cognitive and physical limitations that can last a lifetime).

² The HCI for Africa Region is 0.40 (lowest amongst all Regions), and the target for 2023 (aligned with the Sustainable Development Goals and World Bank Group's Africa Strategy) is to increase to 0.45.

³ Country Partnership Framework 2019-24.

⁴ In 2014-2016, net official development assistance to Liberia represented 45.3 percent of its GDP and amounted to almost 2.3 times Liberia's gross capital formation—one of the highest ratios in the world.

⁵ The poverty rate measured at the international poverty line of US\$1.90 per day in purchasing-power-parity terms stood at 38.6 percent in 2014, while the poverty rate measured at the national poverty line exceeded 50 percent in 2016, with rates ranging from 71.6 percent in rural areas to 31.5 percent in urban centers

⁶ Global Health Expenditures Database from WHO

⁷ MOH 2017

⁸ 2014 household survey. Catastrophic health expenditures are defined as 10% of total household consumptions.

⁹ Payment of outpatient services mostly apply to public facilities per the 2014 household survey. 72% of households went to a public health provider while 18% visited a private for-profit provider.



counter payment for drugs are the main drivers of out of pocket (OOP) spending. The country's per capita health expenditure remains low at \$72 (current US dollars), below the \$86 threshold necessary to provide a basic package of health services.¹⁰ 49 percent of the sector's financing came from external resources in 2014 and the rest came from public resources and private household expenditures.

Liberia's health outcomes are sub-optimal, and access to health services suffer wide socio-economic and geographic disparities in coverage. The poorest are twice as likely to encounter problems in accessing reproductive health care compared to the richest¹¹. The gap in antenatal coverage is 7 percentage points higher for the richest than the poorest, this gap widens to 46 percentage points for coverage of skilled birth deliveries. Similarly, children aged 12-23 months from the richest population are 1.6 times more likely to receive full vaccination compared to those from the poorest. Furthermore, children under five from the richest population are 1.2 times as likely to have febrile treatment sought for them from a healthcare provider compared to those from the poorest population. Consequently, outcomes are worse for the poorest. For example, children under five from the poorest population are 1.7 times more likely to be stunted, and twice as likely to be underweight compared to those from the richest¹². In 2016, the share of women accessing postnatal care ranged from 50 percent in Bong County to 17 percent in Margibi County. Similar variations were observed across indicators of child healthcare coverage, and full-immunization rates for children below the age of one ranged from 94.5 percent in Bong County to just 34 percent in River Gee.

Adolescent health and fertility remain an area of concern. Adolescents and youth¹³ (10-24 years old) represent approximately one third of the total population in Liberia. Female and male adolescents and youth population account for nearly one third of total female and male population respectively (32 percent each). Estimates indicate that Liberia's adolescent fertility rate (129 births per 1,000 women age 15-19 years) ranks the fourth among West African countries, after Niger, Mali, and Guinea (194 births, 171 births, and 137 births per 1,000 women age 15-19 years respectively)¹⁴. Compared to its neighboring countries – Sierra Leone and Guinea, Liberia experienced the lowest rate of decline in adolescent fertility rate between 2000 and 2016. Improving adolescent sexual and reproductive health outcomes is a priority area of investment to create the conditions for demographic transition and human capital accumulation for women and girls. Adolescent fertility contributes to total fertility and limits the ability of young women to accumulate human capital. Fertility is both a driver of Human Capital outcomes and puts efforts to improve Human Capital at risk. Regional experience shows that rapid progress is possible – Senegal, Malawi, Uganda and Rwanda reduced adolescent fertility rate by more than 6 percent a year.¹⁵ Multisectoral interventions, including focused behavior change will be key drivers.

Coordinated response of the Government and Development Partners to RMNCAH. To address some of the key lagging health outcomes in the country, GOL has prepared and endorsed the Reproductive, Maternal, Child, and Adolescent Health (RMNCAH) Investment case (IC) (2016-2020). Implementation of the IC is funded by GOL and development partners including the World Bank/Global Financing Facility (GFF) Trust Fund, USAID, Global Fund, UNICEF, WHO, UNFPA, Government of Japan, GAVI, BMZ, International Planned Parenthood Federation and Last Mile Health. The IC accelerates strategies to improve essential health services nationally, prioritizing six out of fifteen counties with comparatively worse RMNCAH indicators and fewer resources. The six priority areas are: (i) quality EmONC including antenatal (ANC) and

¹⁰ High Level Task Force on Innovative International Financing for Health 2009 estimates.

¹¹ Based on analysis of data from 2017 World Development Indicators (WDI) dataset

¹² All other data referenced in this paragraph were based on analysis of the 2013 LDHS

¹³ World Health Organization (WHO) defines young people as individuals between ages 10 and 24. Adolescents represent the 10-19 years old age group and youth represent the 15-24 years old age group.

¹⁴ WDI 2018

¹⁵ The Africa Human Capital Plan, draft March 2018, The World Bank



postnatal care (PNC) and child health; (ii) strengthening the civil registration and vital statistics (CRVS) system; (iii) adolescent health interventions to prevent mortality and morbidity during antenatal, childbirth, and postpartum periods, unsafe abortion, early and unintended pregnancy and sexually transmitted infections, and gender-based violence; (iv) emergency preparedness, surveillance and response, especially maternal and neonatal deaths surveillance and response (MNDSR); (v) sustainable community engagement; and (vi) leadership, governance and management at all levels.

Plans and programs are in place, but binding constraints often hinder the attainment of desired results. In addition to the RMNCAH IC, during the last few years, many elaborate plans have been prepared and agreed to improve Liberia's health system and its corresponding health indicators. These plans, however, have usually not been implemented as planned; and where implemented, the focus has largely been on technical solutions. It is becoming apparent that technical reforms will need to be supported by governance, institutional and organizational reforms for sustainability of impact. *There are a range of underlying critical challenges that Liberia faces, and these translate into some of the key binding constraints to implementation. These include human resource management, drug procurement and supply chain management systems, public financial management and efficiency, bringing citizen voice into health governance, and improving transparency and accountability at all levels of the system.* Digitization and technology provide opportunities that have not yet been used to the fullest in the country.¹⁶ The proposed project will be designed to address these binding constraints.

Relationship to CPF

This World Bank Group (WBG) Country Partnership Framework (CPF) for FY2019-FY2024 describes the main elements of the World Bank Group's (WBG) support to Liberia as it strives to achieve sustainable, resilient, pro-poor economic growth. The CPF lending program embodies the key strategic shifts from the heavily skewed infrastructure portfolio of the previous Country Partnership Strategy (CPS) towards a strong focus on education, agriculture, economic empowerment of women and youth, and maternal and child health. Therefore, the CPF investment portfolio will increasingly concentrate on human development and intangible capital. The overarching goal of the CPF is to support Liberia as it strives to achieve pro-poor, private sector-led growth underpinned by human-capital development, institutional capacity-building, infrastructure development, and economic diversification.

The proposed project aims to primarily support the first of the three pillars of the CPF (strengthening institutions: objective 1), towards building human capital (objective 6), which is the second pillar.

The proposed project will align and expand the support of the interventions financed by the GFF Trust Fund to support the implementation of the RMNCAH IC.

C. Proposed Development Objective(s)

To strengthen institutional management for enhanced health services to women, children and adolescents in Liberia.

Key Results (From PCN)

1. Enhanced engagement of communities, non-state actors and local leaders to address the burden of adolescent health and nutrition and teenage pregnancies.

¹⁶ Technology and innovation offer countless opportunities to address supply and demand side constraints to Human Capital acceleration.



2. Effective performance management system for all cadres and at all levels in the health system.
3. Effective and efficient drug procurement and supply chain management system enabling reduced stock-outs at last mile service delivery.
4. Timely availability of reliable health services data (disaggregated by gender and age groups) at all levels of service delivery.
5. Streamlined and transparent system operational to ensure allocation, expenditure and reporting of funds from center to decentralized levels in the health system.
6. Expanded hospital and county performance-based financing.

D. Concept Description

Proposed Project Components. During project preparation the task team will work with the government to articulate and define areas/components that would be best addressed by financing defined results, and those that would benefit from traditional input-based financing.

- i. *Addressing adolescent health and well-being:* Further work will be done during project preparation to define the scope of support in this critical area of concern with the longer-term objective of contributing to reduced teenage pregnancies and maternal mortality. Any significant supply-side constraints to service delivery relate to human resources and supply chain and would be addressed as part of those components. Therefore, this component would likely focus on community engagement and behavior change (learning from the Sahel Women's Empowerment and Demographic Dividend Project - SWEDD) using non-state actors, and leveraging the investments made by the Education Sector in Liberia, including Bank financing.
- ii. *Improved human resource management:* This proposed component would support a more efficient human resource strategy and performance management system. This would include addressing critical weaknesses in the current system - lack of clear job descriptions, non-existent career paths, no transparency in selection, postings and transfers, urban-rural disparity, untimely payment of salaries, disparity in salaries, and incentives and motivation. Enabling the creation and implementation of effective strategies for human resource management will encourage equitable distribution and retention of motivated professional and health support staff and support better service delivery across the health system of Liberia.
- iii. *Effective supply chain management:* This proposed component would aim to support the reach of drugs and supplies to the last mile, including family planning and reproductive health commodities. It would include – strengthening procurement management and forecasting, improving Inventory management and logistics, warehousing - accessibility, security, stock management (no infrastructure), information systems. Enabling proper planning, budgeting and execution of procurement and quality assurance will lead to reductions in drug stock-outs and enable the timely availability of drugs at health facilities and to all populations.
- iv. *Enhanced and reliable data availability and evidence-based decision making:* This proposed component would support to improve the current lack of availability of reliable and timely data at all levels across all functions; and accountability in data reporting and evidence-based decision making. It would include establishing standards and procedures for effective information flows for ensuring availability of reliable and timely data at all levels and across all functions effective planning and management; incentivizing facility-level use of data for implementation, and at higher levels for decision-making; and mechanisms for data sharing with communities. Improved systems



will allow for regular data capture and monitoring of disaggregated data which can be consolidated and used for planning and decision making. Strengthened citizen engagement by improving their access to information and capturing their voice and feedback will improve state responsiveness in addressing constraints to access. Improved accountability will help encourage service providers to “supply” the services for which they are responsible.

- v. *Efficient public financial management:* The health sector faces several PFM challenges that hinder effective and efficient service delivery. A PFM project currently being designed has analyzed some of these challenges. Budgetary processes in the sector are less participatory which reflects poor communication and collaboration among Ministry of Health (MoH) departments and units. Staffing in specialized areas such as accounting and at the CHT levels remains weak. The budget of the MoH does not follow the MTEF to ensure a long-term view to providing services. Planning for budget execution remains difficult due to budgetary allocation uncertainties that lead to low budget execution rates, thereby adversely impacting service delivery. At the County Health Team (CHT) levels, implementation does not follow cash forecasts, as allotments received often vary widely from forecasts submitted to the ministry. No budget analysis is done at the CHT which results in key input for the budget preparation process remaining weak. Delays have been persistently observed in cash transfers to service delivery points. The PFM project proposes to support some critical DLIs that seeks to improve the comprehensiveness and reliability of MoH’s planning and budgeting processes, as well as boost its financial reporting capacity for greater financial reporting and transparency. The component under this project will further support resolution of some of the PFM challenges facing the health sector including in the areas of specialized staffing and developing capabilities for budget management and financial management at the county level. This component will be developed further and build on inputs from the proposed Public Financial Management. Improved PFM in the health sector will reduce existing inefficiencies in public expenditure planning and spending and thereby facilitate better redistribution of resources through more evidence-based resource allocation to ensure that affordable and appropriate health services are delivered to Liberia’s population, particularly the disadvantaged.
- vi. *Building on the successes and implementation of hospital and county PBF:* The project would continue and expand its support to PBF at hospital and county level, to ensure going to scale with the approach that enhances accountability for results. Any remaining funds in the current project, due to initial delays in implementation, would be carried over to support this, provided IDA funds will be available to co-finance this important area of accountability for results to ensure scalability and enhance sustainability.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No
Summary of Screening of Environmental and Social Risks and Impacts	
In view of the nature of the proposed project activities, the Environmental and Social Standard (ESS) 1 does apply. The initial assessment of the project components anticipates potential risks and impacts related to (i) Non-discrimination and inclusion of vulnerable and disadvantaged groups– this will be particularly relevant to the component that supports adolescent reproductive health and teenage pregnancy, given the extensive stakeholder engagement and	



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

Note To view the Environmental and Social Risks and Impacts, please refer to the Concept Stage ESRS Document.

CONTACT POINT

World Bank

Preeti Kudesia
Senior Health Specialist

Borrower/Client/Recipient

Republic of Liberia
Honorable Samuel D. Tweah Jr.
Minister of Finance
mfdp@gov.lr

Implementing Agencies

Ministry of Health
Mr Matthew T.K. Flomo
Project Coordinator
matt77us@gmail.com



The World Bank

Institutional Foundations to Improve Services For Health (P169641)

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: <http://www.worldbank.org/projects>

APPROVAL

Task Team Leader(s):	Preeti Kudesia
----------------------	----------------

Approved By

Practice Manager/Manager:		
Country Director:		