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INTERNATIONAL DEVELOPMENT ASSOCIATION

RESTRUCTURING PAPER

ON A

PROPOSED PROJECT RESTRUCTURING FOR THE

HEALTH SYSTEMS STRENGTHENING PROJECT
CREDIT 5244-LR AND GRANT TF014432-LR

APPROVED ON MAY 30, 2013
TO THE
REPUBLIC OF LIBERIA

AND A GRANT FROM THE

GLOBAL FINANCING FACILITY (GFF) in support of Every Woman Every Child
IN THE AMOUNT OF US$16 MILLION

TO THE

REPUBLIC OF LIBERIA

January 30, 2017

Health, Nutrition & Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective December 31, 2016)

Currency Unit	=	Liberian Dollars (LR$)
LR$91.00	=	US$1
US$1.38	=	SDR 1

FISCAL YEAR
July 1 – June 30

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
ANC	Antenatal Care
ANC4	Antenatal Care 4th visit
ARV	Antiretrovirals
ASRH	Adolescent Sexual and Reproductive Health
AYF	Adolescent and Youth-Friendly
BEmONC	Basic emergency obstetric and neonatal care
CDC	United States Center for Disease Control
CEBS	community event-based surveillance
CHA	Community Health Assistant
CHT	County Health Team
CNDRA	Center for National Documents and Records Agency
CRVS	Civil Registration and Vital Statistics
eDEWS	electric Disease Early Warning System
EERP	Ebola Emergency Response Project
EmONC	Emergency Obstetric and Newborn Care
EOC	Emergency Operations Center
EVD	Ebola Viral Disease
EWARN	Early Warning and Alert Response Network
FCC	Fragile and Conflict Countries
GFF	Global Financing Facility
GMRP	Graduate Medical Residency Program
gCHVs	General Community Health Volunteers
GOL	Government of Liberia
HCW	Health Care Worker
HCWMP	Healthcare Waste Management Plan
HMIS	Health Management Information Systems
HIV	Human Immunodeficiency Virus
HRITF	Health Results Innovation Trust Fund
HSSP	Health Systems Strengthening Project
HWP	Health Workforce Program
IDA	International Development Association
IDB	International Development Bank
IDSR	Integrated Disease Surveillance and Response
IFC	International Finance Corporation

IHP+	International Health Partnership
IPC	Infection Prevention Control
LDHS	Liberia Demographic Health Survey
LISGIS	Liberia Institute for Statistics and Geo-Information Services
MIA	Ministry of Internal Affairs
MOF	Ministry of Finance
MoH	Ministry of Health
MMR	Maternal Mortality Ratio
NDS	National Drug Service
NGOs	Non-Governmental Organizations
PAs	Physician Assistants
PBF	Performance-based Financing
PDO	Project Development Objective
PHRD	Policy and Human Resources Development Fund
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnership
REDISSE	Regional Disease Surveillance Systems Enhancement Project
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
TA	Technical assistance
U5M	Under-five mortality
U5MR	Under-five mortality rate
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WAHO	West Africa Health Organization
WHO	World Health Organization

Regional Vice President:	Makhtar Diop
Country Director:	Henry G. Kerali
Country Manager:	Larisa Leshchenko
Senior Global Practice Director:	Timothy G. Evans
Practice Manager:	Gaston Sorgho
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	Shunsuke Mabuchi

LIBERIA
HEALTH SYSTEMS STRENGTHENING PROJECT
ADDITIONAL FINANCING (P162477)

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Health Systems Strengthening Project- Additional Financing (P162477)

AFRICA

GHN07

Basic Information – Parent			
Parent Project ID:	P128909	Original EA Category:	B - Partial Assessment
Current Closing Date:	30-May-2018		

Basic Information – Additional Financing (AF)			
Project ID:	P162477	Additional Financing Type (from AUS):	Scale Up
Regional Vice President:	Makhtar Diop	Proposed EA Category:	B
Country Director:	Henry G. R. Kerali	Expected Effectiveness Date:	30-May-2017
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	30- May-2020
Practice Manager/Manager:	Gaston Sorgho	Report No:	PAD2240
Team Leader(s):	Rianna L. Mohammed-Roberts, Shunsuke Mabuchi		

Borrower

Organization Name	Contact	Title	Telephone	Email
Ministry Of Finance and Development Planning	Boima S. Kamara	Minister for Finance and Developme nt Planning		bkamara@mfdp.gov.lr

Project Financing Data - Parent (Liberia Health Systems Strengthening-P128909) (in USD Million)

Key Dates

Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P128909	IDA-52440	Effective	30-May-2013	03-Jul-2013	16-Jun-2014	30-May-2018	30-May-2020
P128909	TF14432	Effective	30-May-2013	03-Jul-2013	16-Jun-2014	30-May-2018	30-May-2020

Disbursements

Project	Ln/Cr/TF	Status	Currency	Original	Revised	Cancelled	Disbursed	Undisbursed	percent Disbursed
P128909	IDA-52440	Effective	XDR	6.70	6.70	0.00	3.87	2.83	57.79
P128909	TF14432	Effective	USD	5.00	5.00	0.00	0.00	5.00	0.00

Project Financing Data - Additional Financing Liberia Health Systems Strengthening Project- Additional Financing (P164277)(in USD Million)

[ ] Loan [X] Grant [] IDA Grant
[] Credit [ ] Guarantee [] Other

Total Project Cost:	16.00	Total Bank Financing:	16.00
Financing Gap:	0.00		

Financing Source – Additional Financing (AF)	Amount
Borrower	0.00
Grant from Global Financing Facility	16.00
Total	16.00

Policy Waivers

Does the project depart from the CAS in content or in other significant respects?	No
Explanation	
Does the project require any policy waiver(s)?	No
Explanation	
Has the waiver(s) been endorsed or approved by Bank Management?	No
Explanation	

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Rianna L. Mohammed-Roberts	Team Leader (ADM Responsible)	Senior Health Specialist	Health/ Project Management	GHNDR
Shunsuke Mabuchi	Team Leader	Senior Health Specialist	Health/ Project Management	GHNDR
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Mugambi Mugisha Mwendia	Team Member	Finance Analyst	Disbursement	WFALA
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Sybille Crystal	Team Member	Senior Operations Officer	Operations Advisory, Quality control	GHNDR
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Sekou Abou Kamara	Safeguards Specialist	Environmental Specialist	Environment	GENDR
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Lemu Ella Makain	Team Member	Team Assistant	Team assistance	AFMLR

Extended Team

Name	Title	Location
Ok Pannenborg	STC (Medical Education Specialist)	Washington DC

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Liberia	Nimba County	Nimba County	X		

Liberia	Montserrado County	Montserrado County	X		
Liberia	Lofa County	Lofa County	X		
Liberia	Bong County	Bong County	X		
Liberia	Sinoe County	Sinoe County	X		
Liberia	Grand Cape Mount County	Grand Cape Mount County	X		
Liberia	Bomi County	Bomi County	X		
Liberia	Gbarpolu County	Gharpolu County	X		
Liberia	Rivercess County	Rivercess County	X		
Liberia	Grand Bassa County	Grand Bassa County	X		

Institutional Data

Parent (Liberia Health Systems Strengthening-P128909)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change

[X] Fragile, Conflict & Violence

[X] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total percent must equal 100)

Major Sector	Sector	Percent	Adaptation Co-benefits percent	Mitigation Co-benefits percent
Health and other social services	Health	46		
Public Administration, Law, and Justice	Public administration-Health	25		
Education	Tertiary education	21		
Public Administration, Law, and Justice	Central Government administration	8		
Total		100		

Themes

Theme (Maximum 5 and total percent must equal 100)

Major theme	Theme	Percent
Human development	Health system performance	75
Human development	Education for the knowledge economy	25
Total		100

Additional Financing Health Systems Strengthening Project- Additional Financing (P164277)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change

[X] Fragile, Conflict & Violence

[X] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total percent must equal 100)

Major Sector	Sector	Percent	Adaptation Co-benefits percent	Mitigation Co-benefits percent
Health and other social services	Health	80		
Public Administration, Law, and Justice	Public administration-Health	20		

Themes

Theme (Maximum 5 and total percent must equal 100)

Major theme	Theme	Percent
Human development	Health system performance	50
Human development	Population and reproductive health	35
Human development	Child health	15
Total		100

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required?
Consultants will be required

RESTRUCTURING PAPER

I. Introduction

1. This Restructuring Paper seeks the approval of the Executive Directors (EDs) to introduce changes to the original project, the *Liberia Health Systems Strengthening Project (HSSP), P128909 / IDA 52440*. The proposed changes, which include revision to the Project Development Objective (PDO) and results framework, are consistent with a Level 1 restructuring which require the approval of the EDs. The Regional Vice President, Africa Region, has approved a grant amount of US$16 million from the the Global Financing Facility (GFF) in support of Every Woman Every Child as additional funds to support the project.

2. The proposed Additional Financing (AF) will expand the scope of work under the HSSP by providing support for the implementation of the country's reproductive, maternal, newborn, child, and adolescent health (RMNCAH) investment case (IC). This IC is consistent with the priorities identified in the National "Investment Plan for Building a Resilient Health System: 2015 to 2021", and has been developed with support from the GFF in Support of Every Woman Every Child. The proposed restructuring would entail a revision of the PDO in order to reflect the expanded scope of work. The revised PDO is to: "improve the quality of primary and secondary health care services, with a focus on maternal, neonatal and child health". The proposed restructuring would also: (a) extend the project closing date by 24 months with a new closing date of May 30, 2020, to allow for the increased scope of work and mitigate delays in implementation of the original operation due to the Ebola crisis; (b) revise the results framework in order to reflect the AF activities and the proposed extended project closing date; (c) reallocate funding across categories of disbursement; (d) change component titles and the allocation of costs across components, to also reflect the AF funding; and (e) change the disbursement arrangements to include a new Designated Account, in a financial institution acceptable to IDA, for the purpose of receiving advances from the AF.

3. The GFF is a country driven partnership that aims to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, adolescents and children, and thereby prevent up to 3.8 million maternal deaths, 101 million child deaths, and 21 million stillbirths in high burden countries by 2030. The GFF seeks to support countries with an integrated health system approach in order to improve RMNCAH outcomes. The GFF acts as a pathfinder in a new era of financing for development by pioneering a model that shifts away from focusing solely on official development assistance to an approach that combines external support, domestic financing, and innovative sources for resource mobilization and delivery (including the private sector) in a synergistic way. To do this, the GFF aims to reduce inefficiency in health spending through smarter financing, resulting in a reduction in the resource needs for RMNCAH by 2030. The GFF also aims to mobilize additional funding through the combination of grants from a dedicated multi-donor trust fund (the GFF Trust Fund), financing from IDA and the International Bank of Reconstruction and Development (IBRD), and the crowding-in of additional domestic and external resources.

II. Background and Rationale for Additional Financing in the amount of US$16 million[1]

Health Challenges in Liberia

4. **The Liberia country context was re-defined with the Ebola Virus Disease (EVD) crisis** which resulted in reduced economic growth for the country. Liberia's economic growth in 2014 was less than 1 percent, compared with a previously projected level of 6 percent. The country's fiscal deficit also substantially widened from 1.9 percent of GDP in FY13/14 to nearly 10 percent of GDP in FY14/15. In addition, the already fragile employment situation was adversely affected, with an estimated 50 percent of the working population no longer employed as a result of the impact of the Ebola crisis.[2] Inflation hiked to above 13 percent at the peak of the crisis, with adverse impacts on food security. Also, the EVD crisis severely constrained the ability of the Government of Liberia (GOL) to deliver key social services, including basic and secondary health services, thereby leading to many preventable deaths.

5. **The Ebola Virus Disease (EVD) outbreak eroded a number of previous gains, and further weakened the already fragile health system**. Deliveries by skilled birth attendants, for example, declined by 7 percent from 2013 to 2014; ANC 4th (ANC4) visits dropped by 8 percent; measles coverage declined by 21 percent from 2013 to 2014; and health facility utilization plummeted by 40 percent (5.5 visits in 2013 to 3.3 visits per inhabitant in 2014). An interruption in essential immunizations also resulted in measles and meningitis outbreaks. Continuing poor health outcomes have been linked to, and compounded by the fact that Liberia lost 10 percent of its doctors and 8 percent of its nurses and midwives to Ebola (i.e. 8.1 percent of its health workers). A 2015 study estimates that the deaths of these health workers may result in an increase in the maternal mortality ratio by 111 percent relative to pre-Ebola rates.[3]

6. **Post-conflict conditions, coupled with the more recent impact of the EVD outbreak, place Liberia at the bottom of global rankings for maternal, neonatal and child health (MNCH)**. The maternal mortality ratio (MMR) remains high, at 1,072 deaths per 100,000 live births, and has continued to increase since 2000. In addition, over one in ten children will die before the age of five, although neonatal mortality has declined by 19 percent percent from 32 to 26 (per 1,000). Liberia's maternal and newborn deaths are driven by preventable and treatable complications. Major causes of maternal deaths are haemorrhage (25 percent), hypertension (16 percent), unsafe abortion (10 percent percent), and sepsis (10 percent). Low family planning coverage and high teenage pregnancies are also known to be major contributors to maternal mortality. Neonatal deaths account for 35 percent of under-five deaths with prematurity, intra-partum related events, and infections as the major causes of deaths, with over 55 percent of neonatal mortality occuring among girls under-15 years compared to 6 percent for those over 19 years. This indicates the need to delay child bearing to after age 20 through increased access to sexual and reproductive health (SRH) services.

[1] This section draws heavily from the national RMNCAH IC.

[2] Himelein, Kristen; Kastelic, Jonathan G. 2015. The socio-economic impacts of Ebola in Liberia: results from a high frequency cell phone survey round five. Washington, D.C.: World Bank Group.

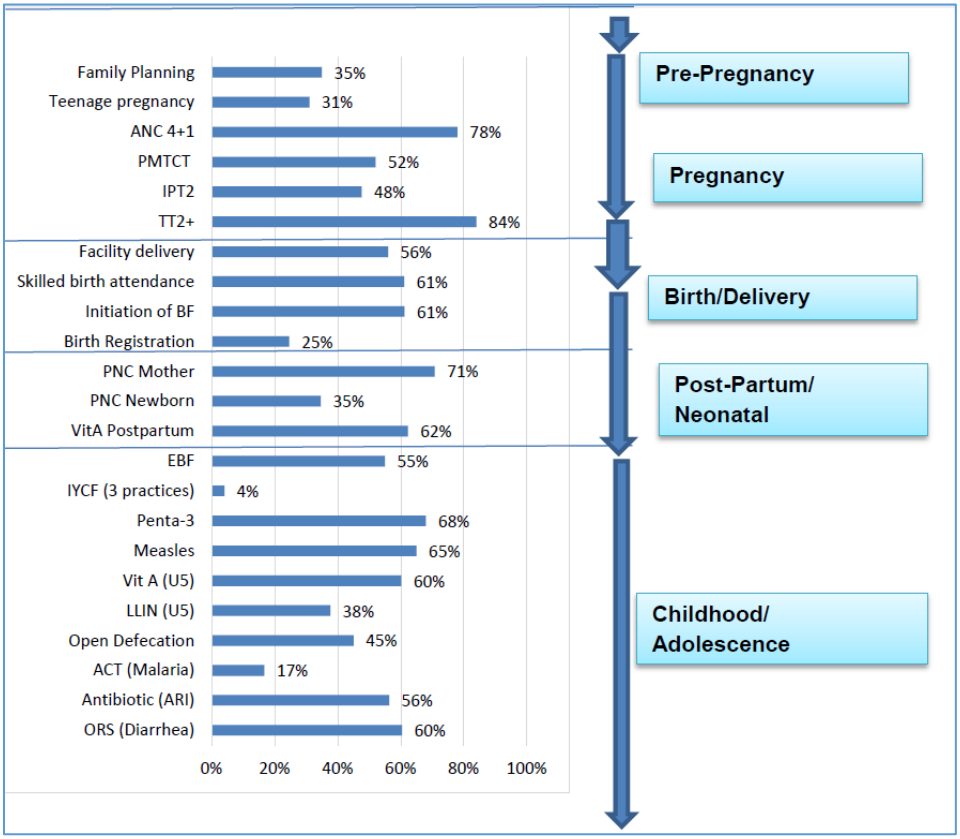
[3] Evans, David; Goldstein, Markus; Popova, Anna. 2015. Health-care worker mortality and the legacy of the Ebola epidemic. The Lancet Global Health. Volume 3, No. 8. This

Key Issues, Gaps, and Priorities

7. **Large variations and gaps exist in key RMNCAH services and interventions**. Figure 1 shows the utilization of health services along with the continuum of care. This shows large variations in utilization of critical services/interventions across different stages of life, and highlights large gaps in family planning, birth registration, PNC for newborn, infant and young child feeding (IYCF), and malaria interventions (LLIN and ACT).

8. **Poor quality of care is a major cause of high maternal and under-five mortality**. Figure 1 demonstrates relatively high coverage of ANC (78 percent), skilled birth attendance (61 percent), and postnatal care for mothers (71 percent). The fact that major causes of maternal and neonatal deaths are pre-term complications and intra-partum related events despite the relatively high services utilization suggests a major challenge with the quality of care provided to women and children (RMNCAH IC, 2016). While 71 percent of women access postnatal care within 48 hours after delivery, only 30 percent of the new-borns actually receive any form of postnatal care by a skilled provider. This also indicates the poor quality of postnatal care services.

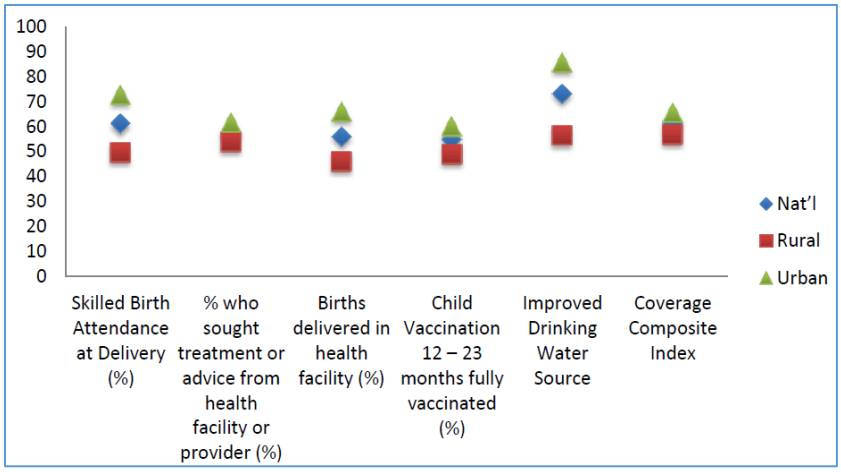
Figure 1: Utilization of health services/interventions across the continuum of care



Source: RMNCAH IC, 2016

9. **There are large geographical disparities in health services that need to be urgently addressed**. Figure 2 shows the urban-rural disparities in skilled birth attendance at delivery and births delivered in health facility, as well as access to safe water. According to the post-Ebola health sector assessment carried out by the MoH and development partners, a total of 29 percent of Liberia's population, particularly those in rural areas, must walk more than 60 minutes or 5 kilometres to reach the nearest primary health care (PHC) facility. A study of remoteness and health care in Liberia found that "greater distance from facilities is significantly associated with reduced care seeking and service utilization among rural populations".[4] This is evidenced by urban-rural disparities in both under-five mortality which was higher in rural areas (120 deaths per 1,000 live births) than in urban areas (106 deaths per 1,000 live births), and full immunization coverage, which ranged from 68 percent in the North-West region to 38 percent in the South-East region.

Figure 2: Urban-Rural differences in health related indicators



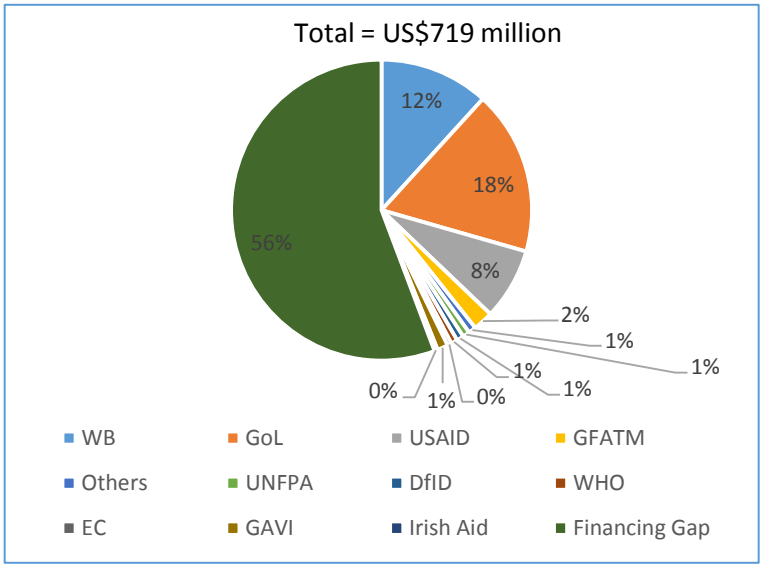
Source: RMNCAH IC, 2016

10. **The RMNCAH IC has identified a number of priority counties** based on a comparison of 20 health indicators/interventions across the 15 counties. The results revealed large differences in the number of low performing indicators (i.e., lower than national average) across counties. Based on this analysis, the RMNCAH IC identified the following six priority counties, which are both remote and have comparatively worse RMNCAH indicators: Gbarpolu, Grand Bassa, Grand Kru, Rivercess, Rivergee, and Sinoe. These priority counties also have a significant shortage of resources.

[4] Kenny, Avi. et al. 2015. Remoteness and maternal and child health service utilization in rural Liberia: A population–based survey. Journal of Global Health. 5(2): 020401.

Figure 3: Resource Mapping- RMNCAH IC for next 5 years

11. **Resource mapping exercises for the RMNCAH IC identified significant gaps**. Implementation of the RMNCAH IC would require US$719 million in the next five years, with a US$400.6 million (56 percent) financing gap. Figure 3 shows partner commitments and the financing gap over the next five years. Domestic resources is estimated to be about US$201 million, which is 40 percent of committed resources and 18 percent of total cost of RMNCAH IC. The World Bank and USAID are the two largest external financiers of the RMNCAH IC, followed by the Global Fund.



Source: RMNCAH IC and Resource Mapping Data

Priority RMNCAH Intervention Areas

12. **Based on the health sector performance analysis and health system assessment, the RMNCAH IC has identified six priority investment areas across the continuum of care to recover essential health services and address health system bottlenecks.** Priority areas are: (i) quality Emergency Obstetric and Newborn Care (EmONC) including antenatal and postnatal care and child health; (ii) strengthening the civil registration and vital statistics (CRVS) system; (iii) adolescent health interventions to prevent mortality and morbidity during the 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.

13. **There are signifant gaps in RMNCAH IC implementation across the priority areas.** Annex 3 summarizes the main activities of different partners and other World Bank projects, along with the RMNCAH IC priority areas. It shows gaps in primary service delivery and Community Health Assistant (CHA) program in RMNCAH IC priority counties, and large gaps in CRVS, MNDSR, and adolescent health activities. This gives a strong rationale for the HSSP AF financed by GFF to focus on these areas and priority counties. These are detailed further below.

(a) Priority Area #1: Quality EmONC

14. **Challenges in quality of care are significant**. The existence of a very high MMR, despite ANC4 coverage of 78.1 percent and 61 percent of births being attended by skilled health personnel, suggests large issues in quality of care. An assessment of the key features of focused ANC, for example, showed limited capacity in detecting signs of pregnancy complications (RMNCAH IC). In addition, a 2010 EmONC survey found that only limited numbers of in-service skilled birth attendants are trained in all signal functions, and a fewer number actually offer these signal functions due to lack of practice and confidence.[5] In addition to the absence of adequate numbers of skilled health workers, an additional challenge to quality pertains to critical gaps in equipment, product availability, and health supply chains in Liberia. Stock-outs often occur at the national and peripheral levels, with product pilferage rampant and distribution mechanisms weak (RMNCAH IC). For example, a 2010 EmONC assessment revealed that 75 percent of health facilities reported stock outs of tracer Family Planning methods, and a general lack of Syphilis testing supplies that are required for focused ANC services.

15. To address the issue of poor quality, this AF will support improvements in access and quality of care at the PHC level, in three RMNCAH IC priority counties: Sinoe, Rivercess, and Gbarpolu.[6] This support will be coordinated with the support being provided by other donors; notably, the United States Agency for International Development (USAID) and the World Bank (through the Ebola Emergency Response Project (EERP)) which is providing technical assistance (TA) and support to both the newly established Quality Management Unit at the MOH, and directly to health facilities in its three priority counties- Lofa, Nimba, Bong, and an additional three counties in the short term- Grand Bassa, Margibi, and Montserrado.

(b) Priority Area #2: Strengthening the CRVS system

16. **The CRVS system is not fully integrated and remains weak**. For example, while birth registration has increased from 4 percent in 2007 to 25 percent in 2013 (LDHS 2013), two parallel systems exist under the MoH for birth registration. Meanwhile, although mandated by law, death registration and certification is generally managed as a voluntary activity, with certificates largely requested only when there is a need to make insurance and other benefit claims. Fragmentation is compounded by the absence of an overarching institution, such as a ministerial steering committee to streamline and coordinate the roles, responsibilities, and activities of the various institutions. To address these issues, the MoH has developed the 2016-2020 CRVS IC. Supporting the CRVS is a GOL priority in the National Investment Plan. The AF will support the implementation of the CRVS IC as a basic social service to its citizens; with a focus on support to setting up the national CRVS system, and the RMNCAH IC priority counties: Sinoe, Rivercess, and Gbarpolu.

[5] For example, only 31.3% of the 73.5% of health workers who had been trained to do internal bimanual uterine compression (a life-saving intervention to stop postpartum hemorrhage, the leading cause of maternal death in Liberia), were actually performing this procedure (RMNCAH investment case).

[6] Notably, the original HSSP directly supports improvements in quality of care, with a specific focus on the hospital level. Hospitals in Liberia remain in generally poor physical condition; are staffed with insufficient numbers of productive, responsive, and qualified staff in key areas of competence; and, have long waiting times and inadequate supplies of equipment and drugs. As a consequence, hospitals in general provide low quality of care.

(c) Priority Area #3: Adolescent health

17. **Adolescent health is a priority** in view of high levels of teenage pregnancies which are known to contribute to maternal mortality. An estimated 31 percent of women between 15 and19 years have begun child bearing. Overall family planning coverage is low at 20 percent and is a priority given that about 30 percent of adolescent pregnancies end in abortions. Adolescent health care services are absent, especially in underserved counties, and where they do exist, there is poor coverage and quality (RMNCAH IC). Through this AF, support will be provided to improve the coverage and quality of family planning and adolescent sexual reproductive health (ASRH) services, largely at the primary level, as well as through community outreach in a number of yet-to-be determined priority counties.

(d) Priority Area #4: Emergency preparedness, surveillance and response, especially maternal and neonatal deaths surveillance and response (MNDSR)

18. **Improving disease surveillance and MNDSR are key areas of focus.** A key lesson learnt from the EVD outbreak and response, is the importance of improving disease surveillance particularly at the community level. Drawing from this, the project will focus on supporting community event – based surveillance (CEBS). This will involve training of Community Health Assistants (CHAs) on the International Classification of Diseases, strengthening reporting tools and channels, social mobilization and community engagement are part of the current strategic plan for Integrated Diseases Surveillance and Response.

(e) Priority Area #5: Sustainable community engagement

19. **CHAs play a critical role in both responding to disease outbreaks, and in providing essential health services**. This was a key lesson learnt from the EVD outbreak and response. Building on this experience, the country is determined to strengthen community engagement. The National Community Health Road Map target is 1 CHA per 350 population living more than five kilometers from the nearest health facility. Achievement of this target will require 4,100 CHAs to be trained and deployed in the next five years. The baseline is currently zero, as there has previously been no formal CHA cadre in Liberia, although there are general Community Health Volunteers (gCHVs), some of whom are expected to be upgraded to CHAs.[7] The MoH's health workforce plan prioritizes Grand Bassa, Grand Cape Mount, and Gbarpolu counties for the CHA program, due to their high disease burdens and largely rural populations. Support to the CHA program will complement existing and planned donor support, both by the Bank and USAID (as detailed in Annex 3).

Priority Area #6: Enabling environment: Leadership, governance, and management

[7] According to the 2013 health workforce mapping report, there are inconsistent levels of competencies among gCHVs. For example, 70% reported not being trained in acute respiratory infection (ARI) case management, 35% were not trained in malaria case management, and 42% were not trained in diarrhea prevention and case management (MoH, 2015).

20. **Support to leadership and governance is critical in ensuring implementation of the RMNCAH IC.** The RMNCAH investment framework will operate under a platform for collaboration and collective action by MOH and the County Health Teams and a wide array of stakeholders including communities, faith based organizations, professional associations and the private sector (for profit and not for profit), development partners and the international community (including the UN agencies). These partnerships are critical to build capacity, support innovations, foster multi-sectoral collaboration across disciplines and invest in research and Performance Measurement and Accountability (PMA) to measure results and track progress. The AF will support this country platform, and in particular, the Health Services Division, and the Department of Planning and Research at the MOH, which is expected to take a leading role in this process. In so doing, support will also be provided to ensure implementation of the RMNCAH IC and monitoring and evaluation (M&E), both on an on-going basis, and at specific milestones during implementation to ensure quality assurance.

Financing for RMNCAH

21. Total health expenditure (THE) has seen a marked increase over the last decade increasing from US$100 million in 2007/08 to over US$365 million in 2013/14 as reported in a series of National Health Accounts (NHA). Despite the fact that the GoL budget allocation has been increasing over the years (reaching 12 percent of the total GoL budget in FY2014/15), it remains a small proportion of the THE. External donors and households - through out-of-pocket payment - are the two main financers accounting each for about 40 percent of total health expenditure. Although the exact amount is difficult to establish, it is well known that a substantial portion of the external financing is provided "off-budget" through NGOs directly to counties and communities. A recent donor mapping exercise by MoH has estimated that close to three-fourth of donor funding is channeled through "off-budget" mechanisms.

22. The health sector encounters two critical challenges related to budget execution and allocation, among others: (a) health budget executions have been consistently lower than the amount allotted (appropriated by legislature); and, (b) the absence of transparent and objective resource allocation criteria has resulted in an inequitable distribution of the health budget across counties. To address these issues, a resource allocation formula (RAF) has been developed by MoH, with the support of the Bank. Operationalization of this RAF, however, has been contrained by a number of challenges, including a significant lack of information on "off-budget" donor funding. The absence of objective resource allocation criteria makes it difficult to attempt any kind of efficiency analyses. As such, it will be critical for the MoH to continue to prioritize the following key activities: firstly, to capture the off-budget donor funding through a comprehensive donor mapping exercise, and secondly, to progressively align the off-budget funding through improved sector coordination and formalizing the aid effectiveness principles through the International Health Partnership (IHP+).

23. Under this project, and with support from the GFF[8], concerted effort will be placed on supporting efforts to operationalize the RAF, with a view to supporting increased allocative efficiency and by extension, improved domestic resource mobilization (DRM).

24. Relatedly, support will also be provided to the establishment of the Liberia Health Equity Fund (LHEF). LHEF is a strategy that proposes to support universal health coverage (UHC) through: (i) strengthening primary health care delivery; (ii) prioritizing sustainable financing for health (with a focus on essential drugs); and, (iii) improving household financial protection. These objectives will be achieved through the following key interventions:

(a) The provision of a subsidized basic health benefit package (focused on RMNCAH) of services that will be scaled out to the population through the primary health care delivery program (including through PBF approaches);
(b) Formulation and pilot testing of a Revolving Drug Fund (RDF) to ensure sustainable and predictable financing for essential drugs for primary health care; and,
(c) Institutionalization of an equity-based allocation of resource distribution for primary health care from central level to counties.

Relationship with CPS

25. The Liberia Country Partnership Strategy (CPS) for the period FY 2013-2017- despite being developed prior to the EVD outbreak- is consistent with activities proposed under the AF. Specifically, building on the lessons learned from the EVD outbreak, proposed activities aim to strengthen the resilience of the health system in the medium-long term. Resilience refers to the ability of the health system to respond to future shocks; for example, epidemic and disease outbreaks. The RMNCAH IC lists the following key cross-cutting areas as being critical for building health system resilience: emergency preparedness, surveillance and response, especially maternal neonatal deaths surveillance and response (MNDSR), sustainable community engagement; and leadership, governance and management at all levels of the health system.

26. The overarching objective of the CPS is to support the Government's Agenda for Transformation (AfT) 2012-2017. The AfT is a five-year development plan which aims to contribute to sustained growth, poverty reduction and shared prosperity, while addressing issues pertaining to fragility, and resilience- building. In addition, the proposed AF is in line with the Human Development Pillar II of the CPS which focuses on increasing access and quality of basic social services and reducing vulnerability; these areas will be addressed through components 1, 2, and 4 of the AF. The proposed AF is also in line with Liberia's post Ebola recovery coordination efforts under which development partners, including the Bank, have agreed on key areas of support in order to minimize duplication, and optimize the use of resources. Specifically, through the HSSP and the HSSP AF, support will be provided in the following areas: strengthening access to quality of RMNCAH services; building the capacity of the health

[8] Support to DRM and other health financing activities under the AF will financed through a Bank-executed TF. This will leverage, to the extent possible, earmarked funding for health financing under the EERP.

workforce; ensuring preparedness to infectious disease outbreaks through support to IPC; and improving the CRVS and M&E systems.

Collaboration with Other Development Partners

27. The GOL signed the international health partnership (IHP+) compact on April 13, 2016, and intends to move toward a sector-wide approach. Building on the IHP+ principle and in light of the partner collaboration under the GFF support, project activities will be supported in close collaboration and coordination with other development partners. Key service delivery activities such as the CHA program and county-based PHC services, as detailed in Annex 3, are geographically coordinated between the Bank and USAID, with other partners such as the Global Fund and Global Alliance for Vaccines and Immunizations (GAVI) coming in to fill gaps in coverage.

28. During the implementation of the project, the progress of key partner activities will be jointly monitored through thematic committees and working groups as detailed under the proposed implementation arrangements below.

Original HSSP

29. The original HSSP consists of: (i) an IDA Credit of SDR 6.7 million (US$10 million equivalent); and (ii) a US$5.0 million Grant from the Health Results and Innovation Trust Fund (HRITF, TF014432). The Project was approved on May 30, 2013, with a closing date of May 30, 2018. The Credit became effective on June 16, 2014, and effectiveness of the Grant was back-dated to June 16, 2014. To date, 58 percent of the Credit has been disbursed. The HSSP was restructured on August 16, 2014 to allocate US$6.0 million of the IDA credit to support the World Bank's emergency response to support control and containment of the Ebola outbreak by adding an Ebola Response Component into the Project. The project development objective (PDO) of the HSSP, post-restructuring is "to improve the quality of maternal health, child health, and infectious disease services in selected secondary-level health facilities, and to support the emergency response needed to contain and control the Ebola outbreak".

30. The original HSSP is currently rated moderately satisfactory on both implementation progress (IP) and attaining the PDO due to sustained efforts to re-initiate and accelerate project implementation in the aftermath of the EVD crisis and response.

Alternatives

31. Alternative financing approaches to AF, including a new stand-alone operation, were considered, but rejected. The AF was seen as being the most appropriate approach, since it exploits synergies under the HSSP, whilst also expanding the scope of work to include more comprehensive RMNCAH service delivery at the community and primary levels, together with improved integration of services. In addition, the AF will allow for continued monitoring of key indicators in the original- and refined- results framework, thereby allowing for improved evidence-based decision-making and resource-allocation.

III. Proposed Changes

Summary of Proposed Changes

The proposed AF will expand the scope of work supported under the HSSP to support the implementation of the country's RMNCAH IC in the medium-long term with clear focus on RMNCAH services.

- **Implementing Agency**: the HSSP Project Coordinating Office is being replaced by the Project Implementation Unit (PIU), which is now responsible for the entire World Bank financed HNP portfolio.
- **PDO**: this will be revised to reflect the increased scope of work under components 1, 2 and 4 (discussed below).
- **Loan closing date:** Extension of the project closing date by 24 months with new closing date of May 30, 2020, to allow for the increased scope of work and mitigate delays due to the Ebola crisis.
- **Results Framework:** Both PDO and intermediate indicators are changed significantly in the Results framework, in order to reflect the additional AF activities. The targets of the original indicators will also be revised to reflect the proposed extended project closing date of May 30, 2020.
- **Legal Covenants:** the legal covenants have been updated. Three new covenants have been added, one has been deleted, and one has been revised.
- **Disbursement arrangements**: existing arrangements under the ongoing project will be maintained, however, a new Designated Account will be opened in a financial institution acceptable to IDA for the purpose of receiving advances from the AF.
- **Reallocation between Disbursement categories**: undisbursed funds are being reallocated from Part 4 of the IDA credit, to Part 1. Implementation of activities under Part 4 of the operation- Support to EVD- has been completed.
- **Disbursement estimates**: these are being revised to reflect both the new proposed closing date, and the additional financing.
- **Components and cost**: The titles of three of the four project components and the cost of all four components have been changed to better reflect the increased scope of work arising from the AF.
- **Implementation Arrangements**: while the the Project Technical Committee (PTC) headed by the Chief Medical Officer (CMO)/Deputy Minister of Health Services will continue to meet quarterly to review the progress of project activities, a number of departments (e.g. the Family Health Division) and thematic working groups will have a key role in supporting implementation of new project activities.
- **Implementation Schedule**: The schedule is being revised to take into account both the proposed 24-month extension in the project closing date to allow for the increased scope of work, and mitigate implementation delays stemming from the Ebola crisis and response.

Change in Implementing Agency	Yes [X] No [ ]
Change in Project's Development Objectives	Yes [X] No [ ]
Change in Results Framework	Yes [X] No [ ]
Change in Safeguard Policies Triggered	Yes [ ] No [X]
Change of EA category	Yes [ ] No [X]

Other Changes to Safeguards	Yes [ ] No [X]
Change in Legal Covenants	Yes [X] No [ ]
Change in Loan Closing Date(s)	Yes [X] No [ ]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [X] No []
Reallocation between Disbursement Categories	Yes [X] No [ ]
Change in Disbursement Estimates	Yes [X] No [ ]
Change to Components and Cost	Yes [X] No [ ]
Change in Institutional Arrangements	Yes [X] No [ ]
Change in Financial Management	Yes [ ] No [X]
Change in Procurement	Yes [ ] No [X]
Change in Implementation Schedule	Yes [X] No [ ]
Other Change(s)	Yes [ ] No [X]

Development Objective/Results

Project's Development Objectives

Original PDO

The PDO is to improve the quality of maternal health, child health, and infectious disease services in selected secondary-level health facilities.

Current PDO

The Revised PDO is to improve the quality of maternal health, child health, and infectious disease services in selected secondary-level health facilities; and to support the emergency response needed to contain and control the Ebola outbreak.

Change in Project's Development Objectives

Explanation:

Under the proposed AF, the scope of work under the HSSP will be expanded to support the implementation in the medium-long term of the country's RMNCAH IC. The PDO will be revised to reflect the increased scope of work under components 1, 2 and 4.

New PDO - Additional Financing (AF)

The new proposed PDO is to improve the quality of primary and secondary health care services, with a focus on maternal, neonatal and child health.

Change in Results Framework

Explanation:

On the results framework, two new PDO outcome indicators and seven new intermediate outcome indicators have been added; these reflect the new AF-financed activities, and also include three new corporate level core indicators. The targets of the original indicators have also been revised to reflect the proposed extended project closing date of May 30, 2020.

Compliance

Other Changes to Safeguards
Explanation:

Covenants - Additional Financing (Liberia Health Systems Strengthening Project- Additional Financing – P164277)

Source of Funds	Finance Agreement Reference	Description of Covenants	Date Due	Recurrent	Frequency	Action
GFF	Institutional Arrangements, Schedule 2, Section I.F. 1	The Recipient shall, no later than three [3] months after the Effective Date hire and thereafter maintain, throughout the implementation of the Project, an independent Verification Agency, with staffing, functions and resources satisfactory to the World Bank.	31-Aug-2017	X	Continuous	New
GFF	Institutional Arrangements, Schedule 2, Section I.E 1	The Recipient shall no later than three (3) months after the Effectiveness Date hire for at least one year, an independent TA agency, with staffing, functions and resources satisfactory to the World Bank.	Three months after the effective date	X	Continuous	New
Covenants - Parent (Liberia Health Systems Strengthening - P128909)						
IDA-52440	Institutional Arrangements, Schedule 2, Section I.A.1	The Recipient shall maintain throughout the implementation of the Project, a PTC with functions, composition and resources satisfactory to the Association, to be responsible for, *inter alia*, overseeing the implementation of the Project.		X		No Change
IDA-52440	Institutional Arrangements, Schedule 2, Section I.A.2	The PTC shall: (a) meet quarterly; and (b) be chaired by the Deputy Minister of the Recipient's Department of Health Services		X	quarterly	No Change
IDA-52440	Institutional Arrangements, Schedule 2, Section I.B. 1 and 2	The Recipient shall maintain, throughout the implementation of the Project, the PIU for the Project with staffing, functions, and resources satisfactory to the Association.		X		New

IDA-52440	Institutional Arrangements, Schedule 2, Section I.C	The Recipient shall maintain, throughout the implementation of the Project, a PBF Unit, with staffing, functions and resources satisfactory to the Association (with responsabilities set forth in the covenant).		X		No Change
IDA-52440	Institutional Arrangements, Schedule 2, Section I.D	The Recipient shall maintain, throughout the implementation of the Project, the Liberia College of Physicians and Surgeons ("LCPS")[9], with staffing, functions and resources satisfactory to the Association (with responsabilities set forth in the covenant).		X		Revised
IDA-52440	Institutional Arrangements, Schedule 2, Section I.F	The Recipient shall, no later than three [3] months after the Effective Date hire and thereafter maintain, throughout the implementation of the Project, an independent Verification Agency, with staffing, functions and resources satisfactory to the Association.	Three [3] months after effectiveness	X		New
IDA-52440	Implementation Arrangements, Schedule 2, Section II. D,	The Recipient shall, through the Ministry of Health, enter into and maintain a memorandum of understanding (MOU) satisfactory to the Association, with the LCPS, to set out the respective functions of the LCPS and the Ministry of Health under the Project in developing, administering and implementing the GMRP under Part 2 of the Project.		X		New
IDA-52440	Implementation Arrangements, Schedule 2, Section II.F	The Recipient shall prepare a program of activities (including Training and Operating Costs) proposed for inclusion in the Project during the following calendar year, including: (a) a detailed timetable for the sequencing and implementation of such activities; and (b) a proposed budget and financing plan for such activities.	no later than June 15 each year	X	Annual	No Change
IDA-52440	Implementation Arrangements, Schedule 2, Section II	The Recipient shall provide adequate counterpart funding for Part 2 of the Project, according to the counterpart funding requirements set out in the PIM. | Frequency :		X	Annual	Marked for deletion

[9] The LCPS was referred to as the Postgraduate Medical Council (PGMC) under the original HSSP operation.

IDA-52440	Implementation Arrangements, Schedule 2, Section II.G	The Recipient shall ensure that the Project is carried out in accordance with the guidelines, procedures, timetables and other specifications set forth in the Safeguard Documents.		X		No Change
IDA-52440	Implementation Arrangements, Schedule 2, Section III.A	The Recipient shall monitor and evaluate the progress of the Project and prepare Project Reports in accordance with the provisions of Section 4.08 of the General Conditions and on the basis acceptable to the Association.		X	Semi-annually	No Change
IDA-52440	Implementation Arrangements, Schedule 2, Section III.B	The Recipient shall maintain or cause to be maintained a financial management system in accordance with the provisions of Section 4.09 of the General Conditions.[10]		X		No Change
IDA-52440	Institutional Arrangements, Schedule 2, Section I.E.1	The Recipient shall no later than three (3) months after the Effectiveness Date hire for at least one year, an independent TA agency, with staffing, functions and resources satisfactory to the Association.	Three months after the effective date	X	Continuous	New

Conditions

Source Of Fund	Name	Type
GFF	Effectiveness; Termination Condition GA Article IV, Section 4.01, (a) and (b)	Effectiveness

Description of Condition

(a) The exection and delivery of this Agreement on behalf of the Recipient has been duly authorized or raified by all necessary governmental action and (b) the Recipient has update the Project Implementation Manual (PIM) in form and substance satisfactory to the World Bank.

Source Of Fund	Name	Type
GFF	Withdrawal Condition GA Reference Schedule 2, Section V, B.1 (b)	Withdrawal

Description of Condition

[No Withdrawal] Under Category (2), until the Recipient has hired an Independent Verification Agency, with skills, experience and under terms of reference, satisfactory to the World Bank.

[10] This includes quarterly interim unaudited financial reports, and annual Audited Financial Statements.

Risk	
Risk Category	**Rating (H, S, M, L)**
1. Political and Governance	S
2. Macroeconomic	S
3. Sector Strategies and Policies	M
4. Technical Design of Project or Program	H
5. Institutional Capacity for Implementation and Sustainability	H
6. Fiduciary	S
7. Environment and Social	M
8. Stakeholders	S
9. Other	
OVERALL	S

Finance

Loan Closing Date - Additional Financing (Liberia Health Systems Strengthening Project- Additional Financing – P164277)

Source of Funds	Proposed Additional Financing Loan Closing Date
IDA	May 30, 2020

Loan Closing Date(s) - Parent (Liberia Health Systems Strengthening - P128909)

Explanation:

The Project closing date will be extended by 24 months to a new closing date of May 30, 2020 for both the original credit and grant. This will allow for completion of the increased scope of work, and mitigate implementation delays stemming from the Ebola crisis and response.

Ln/Cr/TF	Status	Original Closing Date	Current Closing Date	Proposed Closing Date	Previous Closing Date(s)
IDA-52440	Effective	30-May-2018	30-May-2018	30-May-2020	
TF14432	Effective	30-May-2018	30-May-2018	30-May-2020	

Change in Disbursement Estimates (including all sources of Financing)

Explanation:

Disbursement estimates are being revised to reflect both the new proposed closing date, and the additional financing.

Expected Disbursements (in USD Million)(including all Sources of Financing)

Fiscal Year	2015	2016	2017	2018	2019	2020	2021	2022	2023	
Annual	6.00	1.00	5.00	8.00	8.00	3.00	0.00	0.00	0.00	
Cumulative	6.00	7.00	12.00	20.00	28.00	31.00	0.00	0.00	0.00	

Allocations - Additional Financing (Liberia Health Systems Strengthening Project- Additional Financing – P164277)

Source of Fund	Currency	Category of Expenditure	Allocation	Disbursement percent(Type Total)
			Proposed	Proposed
GFF	USD	GDS,WKS,NCS,CS,TRG, CHW costs and OP under Parts 1.2.B and 1.2.C of the Project	6,000,000.00	100
	USD	PBF Grants under 1.2.A of the Project	6,500,000.00	100
	USD	GDS,NCS,CS,OP, Faculty Costs and TRG under Parts 2, 3 and Part 4.2 of the Project	3,500,000.00	100
	USD	DS, NCS, CS, TRG, OP under Part 4.1 of the Project	0.00	100
		Total:	16,000,000.00	

Reallocation between Disbursement Categories

Explanation:

The total cost of the AF is US$16 million, which together with the original HSSP allocation of US$15 million makes the total project financing US$31.00 million. Under the original operation, undisbursed funds are being reallocated from Part 4 of the IDA credit, to Part 1. Implementation of activities under Part 4 of the operation- Support to EVD- has been completed.

Ln/Cr/TF	Currency	Current Category of Expenditure	Allocation		Disbursement percent(Type Total)	
			Current	Proposed	Current	Proposed
TF-14432	USD	GDS,WKS,NC,CS,TRG,OP, PBF GRNT Pt 1	5,000,000.00	5,000,000.00	100.0	100.0
		Designated Account	0.00	0.00	0.0	0
		Total	5,000,000.00	5,000,000.00		
IDA-52440	XDR	GDS,WKS,NCS,CS,TRG,OP, PBF part 1	696,919.00	798,306.79	100.0	100.0
IDA-52440		GDS,WKS,NCS,CS,OP,TRG part 2	1,467,449.00	1,467,449.00	100.0	100.0
IDA-52440		GDS,NCS,CS,OP part 3	533,618.00	533,618.00	100.0	100.0
IDA-52440		Designated Account	0.00	0.00	0.0	0.0

IDA-52440		UN Advances	0.00	0.00	0.0	0.0
IDA-52440		UN Advances	0.00	0.00	0.0	0.0
IDA-52440		GDS, NCS, CS, TRG, OP part 4	4,002,014.00	3,900,626.21	0.0	100.0
		Total:	6,700,000.00	6,700,000.00		

Components

Change to Components and Cost

Explanation: (Details are available in Annex 2.)

The proposed HSSP AF support to the RMNCAH IC priority areas is outlined in Table 1 below. The allocation of funding across components and sub-components is provided in Annex 2, Table 1, along with further details on component activities.

Table 1: RMNCAH IC priority areas and proposed HSSP AF support

RMNCAH IC priority areas	Proposed HSSP AF support
1. Quality EmONC	• 1.2: PBF to primary health care facilities in 3 RMNCAH IC priority counties; • 1.2: CHA program in 3 priority counties
2. CRVS Sytem	• 4.2: Comprehensive support to the interventions in the IC focusing on birth and death registration, in 3 priority counties • 1.2: Birth and death Registration through CHA program
3. Adolescent Health	• 1.2: Targeted demand-side intervention in prioritized counties (TBD) • 1.2: PBF at the PHC level to enhance selected services and community-based outreach
4. Preparedness, MDSR	• 1.2: CEBS through CHA program • [1.1 maternal and neonatal death audit will be supported through the original operation]
5. Community Engagement	• 1.2: CHA program in 3 priority counties
6. Leadership, Governance, Management	• 4.2: Support to family health division, PIU, and other agencies in the country platform for project implementation and M&E.

Component 1: Support to Quality Service Delivery Systems (Original: US$10 million; after Ebola restructuring: US$6 million; This AF: US$13.7 million; total after AF: US$19.7 million): This component aims to improve the quality of care at targeted secondary level facilities and strengthen primary and community-based health services delivery to improve coverage of quality RMNCAH services.

- **Sub-component 1.1: Quality Improvement of Hospitals** (Original activity, with slight changes) aims to strengthen quality improvement at selected secondary-level facilities which cover approximately 30 percent of the population and includes a mix of semi-urban and semi-rural facilities. To make target hospitals accountable and motivated to improve the quality of services provided, a PBF approach will be used, which includes a defined quality checklist. This checklist is comprised of key indicators of interest pertaining to clinical outcomes (e.g. adherence to predefined obstetric protocols), structural aspects of services (e.g. availability of drugs and

equipment) and management aspects that will be incentivized.

This is an original HSSP activity, with the following changes. Firstly, a couple of changes in target hospitals have been made in response to other partners' support in the post-Ebola period. Second, Hospital PBF and quality improvement approaches have been adapted based on the lessons learned from a 9-month pre-pilot that was implemented in Redemption Hospital. One key lesson, for example, has been the need to separate the functions of technical assistance and verification. In response to this, an independent TA agency, and an independant National Verification Agency will be competitively selected. Third, refinements have been made to the quality checklists to ensure, *inter alia*, appropriate attention to Infection Prevention and Control (IPC) in view of post-Ebola disease preparedness. Activities under this sub-component have been significantly delayed by the Ebola outbreak and response, and shifting priorities in the post-Ebola period.

- **Sub-component 1.2: Strengthening Primary and Community-based Health Services to Improve Coverage of Quality RMNCAH Services** (new activity): aims to strengthen PHC and community-based service delivery to improve coverage of quality RMNCAH services. This is a key objective of the country's RMNCAH IC, as well as the "Accelerated Action Plan to Reduce Maternal and Neonatal Mortality". Specifically, the AF will support service delivery at the PHC-level, and increased outreach services by CHAs in rural and hard-to-reach areas through a county-based contracting approach for primary service delivery and support to the CHA program respecitively. Each of these interventions are described briefly below.

A. Performance Based Financing (PBF)

In the county-based contracting-in approach, the MoH will contract county health teams (CHTs) to support health facilities in the provision of a package of essential health services in three RMNCAH IC priority counties: Rivercess, Gbarpolu, and Sinoe. Counties and health facilities will receive performance-based funds based on the quantity and quality of RMNCAH services (such as family planning, ANC, skilled delivery and PNC, birth registration) provided. The PBF as such helps operationalize the RMNCAH IC and its priorities. CHTs will furthermore be incentivised based on their performance in managing and supervising health facilities. Relevant technical assistance (TA) will be provided to build the capacity of county health teams (CHTs) to ensure they are able to carry out this role, and in so doing, mitigate any potential risks. The capacity of the CHTs will be built in critical support functions, such as data analysis and quality improvement as well as financial management and procurement, which contributes to the strengthening of leadership, governance and management priority in the IC.

At the request of the MoH, contracting will build on the approach rolled out with the support of USAID through FARA in six counties where NGOs are co-managing the work of the CHTs. To the extent possible, harmonized manuals and tools will be used for both FARA and the contracting approaches supported through this AF.

B. Community Health Assistant (CHA) Program

This sub-component will support implementation of the "National Community Health Services Policy" in target counties. Under the Policy, trained CHAs and Community Health Services Supervisors (CHSS) will be responsible for providing a comprehensive package of preventive, promotive, and curative services at the household level, for populations residing more than 5km from their nearest health facility. The standardized package of services for CHAs, as defined in the "National Community Health Services Policy", includes household visits, referral of cases to health facilities, community death recording, community disease surveillance and control, home-based family planning, antenatal care (e.g. distribution of misoprostol, pre-natal vitamins, insecticide treated nets, malaria treatment), postnatal care (e.g. preventive misoprostol, vitamin A administration), neonatal care, vaccination drop-out tracing, and integrated community case management (iCCM). The AF will support the roll-out of this standardized package, with the support of a TA agency as needed in the following three counties: Grand Bassa, Grand Cape Mount, and Gbarpolu.

This sub-component will also support other community health cadres as needed to engage with communities to promote community-led activities including: (i) detection, referral, and reporting of suspected diseases of epidemic potential; (ii) community-led total sanitation (CLTS); (iii) support for treatment adherence and stigma reduction for priority diseases; (iv) mobilization of local resources to support health interventions; and (v) participation in planning, implementing, monitoring, and feedback through community health committees (CHC) and health facility development committees (HFDCs).

The EERP is preparing to support the roll-out of a comprehensive CHA program in three priority counties – Grand Bassa, Grand Cape Mount, and Gbarpolu – through a contracted TA agency, as well as five counties in Southeast through UNICEF. This proposed AF will take over support for the CHA Program in three selected counties from the EERP, with support geographically coordinated with a USAID program that rolls out the standardized (CHA) package of activities in six counties (See Annex 2 Figure 2.1 for details). Specifically, the project will finance reasonable CHA costs associated with carrying out the Program, including a monthly stipend, and transportation costs and accommodation costs, based on periodic budgets agreed with the Bank.

C. Adolescent Health Activities

The AF will focus largely on supporting supply-side interventions that integrate adolescent and youth-friendly (AYF) RMNCAH services (e.g., SRH/family planning services to young mothers, STI/HIV prevention and management including HIV testing and counselling, post-abortion care services) at the PHC level, and through CHA outreach services. In addition, funds may be earmarked to finance operational and consultant costs for the MoH to carry out demand-side prioritized adolescent health activities in selected counties focusing on teenage pregnancy. These can include, for example,: school health programs, and community engagement including youths to increase awareness and impact of gendered decisions on adolescents' well-being. The specific activities to be funded under this component will be detailed in the PIM.

Component 2: **Support to Strengthening Fit-for-Purpose Health Workforce** (Original: US$4.2 million; after Ebola restructuring: US$2.2 million; this AF: US$0.5 million; total after AF: US$2.7 million): This component will support the country's health workforce program and improve health worker competencies to address key health-related concerns by supporting the following:

Sub-component 2.1 Support to the Graduate Medical Residency Program (GMRP) - (Original activity): The sub-component will support ongoing efforts to develop and implement an innovative GMRP to increase the number of physicians with specialized certified skills and competencies in critical specialist areas - obstetrics, pediatrics, general surgery and internal medicine. This AF does not affect the original design of this sub-component.

Sub-component 2.2- In-service Training Programs to Mid- Level Health Cadres (Original activity)**:** This subcomponent will leverage the teaching capacity made available under sub-component 2.1 to provide specialized training in critical specialist areas to mid-level cadres (midwives, nurses, and PAs) in target hospitals as well as satellite health centers. This will address a key concern that health workers across all cadres are insufficiently receiving both in-service training and opportunities for continuous professional development (particularly in the areas of obstetrics, pediatrics, internal medicine and general surgery). While the AF does not affect the original scope/ design of this sub-component, a small amount of funding from the AF is now allocated to this sub-component to support operational costs, particularly in the initial stages of the roll-out of this Program.

Component 3: Project Management (Original: US$0.8 million; after Ebola restructuring: US$0.8 million; this AF: US$1.2 million; total after AF: US$2.0 million): This component will support the operational capacity of the MoH to effectively manage the Project (original and AF). This will include support to the operational costs of the

PIU, within the MoH, that will be responsible for coordinating project activities.

Component 4: **Support to Strengthening Critical Services and Support Systems** (Original: US$0 million; after Ebola restructuring: US$6 million; this AF: US$0.6 million[11]; total after AF: US$6.6 million): This component provides support to improving the quality of RMNCAH services (Component 1) and the health workforce program (Component 2).

- **Sub-component 4.1: EVD response support:** This sub-component, which was a component- **Support to the Emergency Response to the Ebola Epidemic"-** under the HSSP Level 1 Project restructuring (approved in August 2014**),** directly supported Liberia's emergency response to the EVD crisis. Specifically, support was provided to: (a) coordination and logistics (through the procurement of vehicles); (b) essential drugs and supplies (including infection prevention and control (IPC) materials); and (c) hazard payments (risk allowance) to health workers in order to incentivize them to engage in both the Ebola response and regular service delivery in health facilities. Activities under this sub-component are completed, with the undisbursed balance - US$1.2 million- being returned to Sub-component 1.1.

Sub-component 4.2: Strengthening Support Functions (New activity): This sub-component aims to strengthen support functions for quality RMNCAH service delivery and the health workforce program, with a focus on support to the M&E and CRVS systems.

(A) Governance and Monitoring and Evaluation of the RMNCAH IC

This sub-component will directly support the country platform needed to ensure the implementation and monitoring of the RMNCAH IC. Specifically, the AF will provide support to the Health Services Division at the MOH and the Planning and Research Department, which is expected to take a leading role in this process, along with relevant technical working groups as needed. These include, the Reproductive Health Technical Committee (RHCT) for service delivery, the supply chain technical working group, health financing technical working group, Human Resources for Health technical working group and the community health service delivery technical working group. In addition to this, and as part of its efforts to ensure that the implementation of the IC is adequately monitored and evaluated, the project will also support data collection, analysis and evaluation efforts, both on an ongoing basis, and at specific milestones during implementation, in order to ensure quality assurance, and mid-course corrections as needed. The precise activities to be funded under this component will be detailed in the PIM.

(B) Civil Registration and Vital Statistics

This subcomponent will support the operationalization of the country's CRVS system, as detailed in the MoH's "Civil Registration and Vital Statistics (CRVS) Assessment: Final Report and Strategic Improvement Plan", its associated Improving civil registration and vital statistics in Liberia Investment Case (2016–2020) and priorities, and as part of the GFF priority initiatives. The focus of this support will be on: (i) birth registration services improvement; (ii) death registration services improvement; (iii) expanding the coverage of the birth and death registration system; (iv) Civil Registration Information System improvement; (v) technical assistance for strengthening legislation; awareness campaigns, and advocacy; and (vi) support for national coordination and Project management, including staffing, monitoring and supervision (including transport and accommodation costs, per diems, motorcycles for community services and Operating Costs).

[11] US$1.8 million AF from the GFF fr sub-component 4.2, subtracted by US$1.2 million to be shifted from sub-component 4.1 to sub-component 1.1, making the total additional funds for this component as US$0.6 million.

Support to CRVS will be on the RMNCAH priority counties, with potential scaling up beyond these counties depending on time and resources. Priority will be given to the birth registration and death registration services given their importance in informing RMNCAH results. The above activities will leverage and supplement service delivery systems at the community, primary, and secondary levels (e.g., immunization campaigns). CHAs as part of their core service package for IDSR, will carry out birth recording and community death recording, with special emphasis on maternal and neonatal death within the community. Birth and death registrations and maternal and neonatal deaths audits will also be carried out and incentivized through PBF at the secondary levels and linked to the CRVS system.

Current Component Name	Proposed Component Name	Current Cost (US$M)	Proposed Cost (US$M)	Action
Strengthening the institutional capacity needed to improve the quality of selected health interventions at PBF health facilities	Support to Quality Service Delivery Systems	6.00	19.7	Revised
Improving health worker competencies to address key health-related concerns at selected health facilities	Support to strengthening fit-for-purpose health workforce	2.20	2.7	Revised
Project Management	Project Management	0.80	2.0	Revised
Support to the Emergency Response to the Ebola Epidemic	Support to strengthening critical services and support Systems	6.00	6.6	Revised
	Total:	15.00	31.0	

Other Change(s)

Change in Institutional Arrangements

Explanation*:* For monitoring of activities, the Project Technical Committee (PTC) headed by the Chief Medical Officer (CMO)/Deputy Minister of Health Services will continue to meet quarterly to review the progress of project activities, while more frequent thematic working group meetings for sub-component activities will be held with key MoH Departments and development partners. The proposed implementation arrangements are summarized in Table 2 below, and will be detailed in the PIM.

Table 2: Proposed implementation arrangements for each activity

Component	Activities	Implementation arrangement
1: Support to Quality Service Delivery Systems	- PBF at 6 hospitals (original activity)	- Regulator: MoH Dept. of health services (Family Health Division (FHD) and County Health Services, Community health Division) and PBF Unit, and CHT for each county - Purchaser: MoH Dept. of Administration - Fund holder: OFM (Office of Financial Management) - Verifier: Competitively selected organization - TA agency: Competitively selected TA agency - Provider: 6 hospitals

	- Support to CHA program - PBF/Support to county contracting service delivery model - Adolescent Health	- MoH Community Health Division. and CHT with possible contracting out management support from a TA firm/NGO; Joint monitoring via CHA task force. - Regulator: MoH Dept. of health services (Family Health Division (FHD) and County Health Services, Community health Division) and PBF Unit - Purchaser: MoH Dept. of Administration - Fund holder: OFM - Verifier: Competitively selected organization - TA agency: Competitively selected TA agency - Implementer: CHT and NGO, and health facilities. - Family Health Division
2: Support to strengthening fit-for-purpose health workforce	- Support to GMRP (including staffing of medical and teaching staff in target hospitals) - In-service training by residents of GMRP	- MoH and LCPS manages the program, with support from the HWP TA hired through EERP
3: Project Management	- Support to strengthen PIU and other management functions.	Integrated PIU
4: Support to strengthening critical services and support Systems	- Procurement of IPC materials, vehicles, and hazard pay	Incident Management System (IMS), PIU
	- CRVS plan implementation - Governance and M&E of the RMNCAH IC	- Department of Planning and Research Development - Department of Health Services - Department of Planning and Research Development

FM and Disbursement. FM and flow of funds will not change; i.e.use of OFM and flow of funds through the existing DA.

Change in Implementation Schedule

Explanation:

The implementation period will be extended by 24 months (proposed new closing date May 30, 2020) to allow for the increased scope of work, and mitigate implementation delays stemming from the Ebola crisis and response.

IV. Appraisal Summary

Economic and Financial Analysis

Explanation:

The overall development impact of the proposed Project will be the improvement of the health of women, children and adolescents. Specifically, the development objective of the Project is to improve the quality of primary and secondary health care services, with a focus on maternal, neonatal and child health. To achieve this

objective, the Project investments will expand the scope of work under the HSSP by providing support for the implementation of the country's reproductive, maternal, newborn, child, and adolescent health RMNCAH investment case through support in the following cost-effective areas, which are summarized below: (a) the CHA program; (b) low-cost interventions at the community and PHC levels; and (c) improved quality of care across all levels of the health system: community, primary and secondary levels.

(a) A comprehensive CHA program is a cost-effective approach to strengthening disease preparedness and prevention of maternal and child health mortality. CHAs are essential in disease surveillance and promoting health prevention. Evidence from the EVD crisis has shown that when adequately incentivized and effectively monitored the potential for effective contribution in health promotion on the part of CHAs can be achieved. Success in case finding was achieved because CHAs were recruited, deployed, and provided remuneration as active case finders/ IPC promoters in communities. These community volunteers are equipped with an understanding of the communities in which they live and hence are more likely to be looped into all informal channels of communication across communities. Learning from these experiences, this cadre can be used as health promoters, as well as surveillance agents, in the delivery of RMNCAH interventions such as distribution of family planning commodities and creating awareness for increasing demand of utilization of the services at community level.

(b) Low-cost community/primary interventions are also highly cost-effective. Liberia's maternal and newborn deaths are driven by a handful of similar preventable and treatable complications that occur predominantly during labor and delivery, and within the first weeks post-delivery. As noted earlier, major causes of maternal deaths in Liberia are: hemorrhage (25 percent), hypertension (16 percent), unsafe abortion (10 percent) and sepsis (10 percent). Neonatal deaths account for 35 percent of under-five deaths with prematurity, intra-partum related events, and infections as the major causes of deaths. As the country develops, with a significant reduction in child deaths between 1 to 5 year old, neonatal deaths will form an even larger proportion of the Child Mortality Rate. The three major killers among children under five years are pneumonia (16 percent), malaria (13 percent), and diarrhea (9 percent). Reducing such preventable causes of death will result in high economic return.

(c) The project also uses comprehensive, evidence-based approaches to improve quality of care. The Project will support comprehensive interventions to strengthen quality service delivery systems at the hospital, PHC and community levels in project target areas and health facilities. Specifically, the project will focus on improving quality service delivery systesms through focused support on improving health worker competencies (through both in-service training, and support to the GMRP), and the provision of performance-based incentives linked to quality (process and structural) improvements at the PHC and hospital levels. It is expected that over time, this quality improvement system will be institutionalized and thereby help to create a quality-oriented culture in these facilities. There is now evidence (including good results from Rwanda and preliminary data from a number of other countries) that result-based systems can change persistent under-performance in the provision of quality health services. Although capacity challenges can affect implementation, this will be mitigated through the hiring of both an international TA agency and independent verification agency- both of which will be competitively selected.

The value added of the World Bank support to Liberia is its extensive technical experience in health systems strengthening- including RMNCAH servive delivery- as well as capacity to mobilize a wide-range of technical expertise to support key strategies and reforms (e.g., RMNCAH investment case, health financing strategy). In addition, the bank has a key convening role in supporting the mobilization and channeling of additional resources to scale-up delivery of effective and efficient RMNCAH services, as Liberia is now part of the GFF in support of Every Woman Every Child (initiative launched by the World Bank and key development partners in September 2014).

In addition to its technical support, the Bank is also currently supporting the GOL in its efforts to coordinate parters and align donor resources around an agreed RMNCAH agenda, as defined in the RMNCAH IC. To this effect, the Bank has: (i) supported the signing of the IHP+ compact for aid coordination; (ii) facilitated joint financial management assessment and M&E assessment to promote sector-wide approach; and (iii) supported the establishment of the aid coordination unit and Minister's Delivery Unit to strengthen oversight functions. In addition, and as noted above, a key objective of the GFF-funding is to support DRM. The Bank is well-placed to support this effort given its extensive in-house expertise in health financing. In close collaboration with the MOH, the Bank has already supported technical analysis on options to increase fiscal space in the health sector, and improve resource allocation at the sub-national levels.

Technical Analysis

Explanation:

Technical Analysis:

The proposed AF has several strong features to ensure achievement of the PDO:

The AF activities focus on gaps in the delivery and quality of high-impact RMNCAH interventions. The CHA program, county-based service delivery support at the primary level, and CRVS activities address key bottlenecks in the service delivery, as identified through the RMNCAH IC. There are also geographical gaps, and gaps in the timing of implementation support being provided by, the Bank-supported EERP, and other partners, including USAID.

The AF activities reflect lessons from EVD outbreaks and responses. Key lessons include the need to integrate preparedness capacity into health systems/ services; the key roles that community members and CHAs can play in disease surveillance and provision of essential health services; and the need for close collaboration and coordination with other partners to achieve large-scale improvements in a short period of time. The AF activities will help to build community-based service delivery programs in remote areas, integrate preparedness and surveillance indicators in the PBF at the PHC level, and continue the collaborative planning and monitoring of each activity with other partners under the MoH's leadership.

The AF activities are consistent, complementary and sequential with other projects/ activities in the Bank's health portfolio in Liberia. Annex 3 summarizes the complementary and sequential relationship between EERP, HSSP and HSSP AF, Ebola Recovery and Reconstruction Trust Fund (ERRTF) support, and the proposed West Africa Regional Disease Surveillance Systems Enhancement Project (REDISSE), for each pillar of the post-Ebola Investment Plan. EERP is supporting the initial process of the Investment Plan, and the HSSP AF and proposed REDISSE will take over initial support. This approach should allow the HSSP AF to leverage support being provided under the EERP.

The project implementation arrangements are cognizant of capacity constraints. The country's weak implementation capacity, particularly at county and health facility levels was further constrained by the EVD outbreak. Despite capacity challenges, however, the country has ambitious plans to rapidly build a stronger and more resilient health system. To assist in the operationalization of these plans, the proposed AF will use experienced firms and NGOs, where necessary, to assist the MoH and county teams, and build their implementation capacity.

Financial Management

The existing FM arrangements under the original HSSP will apply without any major changes.

Procurement

The existing project arrangements under the original HSSP will apply without any major changes.

Social Analysis

Explanation:

Safeguards

There is no major safeguards issue, as infrastructure support under the Component 2 will focus on minor rehabilitation of existing accommodations and facilities. Besides the construction-related safeguards issues, improving the capacity of health care facilities and the procurement and distribution of medical supplies including essential equipment, lifesaving drugs, contraceptives, and medical supplies as envisioned under Component 1 of the project may contribute to impacts arising from handling and disposal of medical wastes and other products usually generated during the provision of health care. The ESMF for the EERP has been revised to reflect the scope of the HSSP AF, and will be used along with the updated Health care Medical Waste Management Plan (HCWMP) to mitigate the potential impacts of the project. The HCWMP was disclosed on October 26, 2015 and does not need to be re-disclosed under this project. The ESMP was re-disclosed in-country on March 04, 2016 It is important to note that no land acquisition or any form of displacement is anticipated as construction/rehabilitation works will be carried out exclusively in existing facilities that are already owned by the GOL.

Citizen Engagement

Based on the lessons leant from the EVD outbreak and response, the project will promote citizen engagement as a key part of the project activities. As per the original HSSP, grievance procedures will be put in place to address any mistreatments/ mishandling between both health workers, and health workers and patients. This will be expanded beyond the target Hospital PBF facilities, to include the PBF PHC facilities (i.e. the expanded scope of work under the HSSP AF). In the case of patients, for example, the Community health leader – who sits on the Hospital Health Board-will be the grievance focal point. Patients will be able to discuss grievances directly with the community health leader, or by writing these down, and placing them in a suggestion box. Health facilities will be required to ensure that grievance procedures are understood by, and understandable to illiterate populations.

All grievances will be discussed at monthly Hospital Board Meetings, with mechanisms to address grievances- in the case of deliberate wrongdoing- enforced. In addition to this, mechanisms to address grievances with and among health workers will also be developed (including redress mechanisms) and enforced by health facilities. Adherence to these grievance mechanisms will be monitored closely in the quality checklist. The specific mechanism that will be followed at the PHC level, will be discussed in detail in the PIM. The response rate to complaints-at the primary and secondary levels- will be monitored as an intermediate outcome indicator.

Second, as a part of the CHA program, the community will be supported to engage in community-led activities including identification and prioritization of relevant RMNCAH problems; detection, referral, and reporting of suspected diseases of epidemic potential; community health interventions, including IPC and community-led total sanitation (CLTS); support for treatment adherence and stigma reduction for priority diseases; and mobilization of local resources to support health interventions. Second, community representatives and civil society groups will participate in planning, implementing, monitoring, and feedback of CHA and health facility activities through community health committees (CHC), health facility development committees (HFDCs), and Hospital Boards.

Environmental Analysis

Explanation:

Under the proposed AF, the environmental category of the project will remain B - due to the potential for

increased medical waste generation from health facilities and the need for proper management and disposal of this waste As mentioned above, the ESMF has been updated and re-disclosed. The HCWMP does not need to be re-disclosed. An Environmental and Social Management Specialist has been hired within the PIU to lead the implementation of ESMF together with the Division of Environmental and Occupational Health (DEOH) at the MoH.

Risk

Explanation:

The overall risk is substantial based on substantial/ high risk ratings for the macroeconomic climate, political and governance, technical design, fiduciary, institutional capacity for implementation and sustainability, and stakeholder engagement. In addition to these risks, the country context remains fragile, and vulnerable.

As at project restructuring in August 2014, the overall risk continues to be Substantial.

Overall health sector risk: The Ebola crisis has resulted in major social, economic and fiscal implications. Substantial fiscal resources, even beyond increased donor contributions, for example, may be required to return the provision of health interventions to pre-Ebola levels, and improve the resilience of the health system to respond to any future epidemics/outbreaks. The EVD, for example, has been responsible for a significant loss of life, particularly among health workers. In addition, there is a deep level of mistrust and fear both among health workers and the general population. This may adversely affect health-seeking behaviors, and the provision of services. The ability to rapidly mobilize the health workforce to, for example, increase the quality and quantity of skilled birth attendants, and strengthen outreach and community-based services to improve coverage of, inter alia, RMNCAH services, may be affected by limited resources, limited capacity for quality assurance and supervision, and limited numbers of suitable and available candidates who can be rapidly trained and decentralized. Mitigation measures across key risks are highlighted below.

Political/ Governance: The Government has made notable progress in building the foundation for improving economic governance, including the strengthening of the General Auditing Commission, improving cash management and controls and establishing the Anti-corruption Commission. Implementation arrangements will be monitored and reviewed during semi-annual supervision missions, and also more frequently if needed. In addition, there will be a strong focus on results, with both ex-ante and ex-post verification and counter-verification at targeted health facilities.

Institutional and/or capacity risk has been considered in the design and implementation of the proposed AF. The proposed AF, combined with the EERP and other sources of external financing, will significantly increase the resources earmarked to support implementation of the country's post-Ebola Investment Plan. However, it may overstretch the limited implementation capacity of the MoH. For capacity related risks, the Project will coordinate closely with the EERP to use extensive Technical Assistance (TA) (e.g. hospital PBF, CHA program, county-contracting service delivery, and HWP) to establish implementation systems and processes and build the MoH's capacity. Also, an integration PIU across the WB portfolio should strengthen the implementation capacity of the HSSP AF.

Stakeholder Engagement: the Project will seek synergies with support being provided by other partners and projects, including under the WB-financed EERP. This will be done through thematic working group arrangements (e.g., the CHA program task force, the HWP steering committee) led by the MoH where all major partners for priority themes participate, individual regular meetings with major partners (e.g., USAID), and a PIU arrangement for the entire WB portfolio. This close coordination will help reduce duplication, and increase the impact of funding in critical areas such as support to the health workforce, and health systems strengthening. Also, it is anticipated that mistrust and fear among general population will be mitigated through improvements in

the quality of care and IPC practices at targeted facilities.

Sustainability: the sustainability risk will be addressed through supporting the GOL in its efforts to increased domestic resource mobilisation and overall health sector efficiency. Both of these efforts are critical, and are already underway.

IV. World Bank Grievance Redress

32. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB'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 WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB 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 Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

ANNEX 1. Results Framework

REVISED RESULTS FRAMEWORK AND MONITORING INDICATORS

Project Development Objectives							
Original Project Development Objective - Parent:							
The Project Development Objective (PDO) is to improve the quality of maternal health, child health, and infectious disease services in selected secondary-level health facilities.							
Current Project Development Objective - Parent:							
The Revised Project Development Objectives are to improve the quality of maternal health, child health, and infectious disease services in selected secondary-level health facilities; and to support the emergency response needed to contain and control the Ebola outbreak.							
Proposed Project Development Objective - Additional Financing (AF):							
The PDO is to improve the quality of primary and secondary health care services, with a focus on maternal, neonatal and child health.							
Results							
Core sector indicators are considered: Yes			Results reporting level: Project Level				
Project Development Objective Indicators							
Status	**Indicator Name**	**Core**	**Unit of Measure**		**Baseline**	**Actual (Current)**	**End Target**
Revised	Maternal death audits carried out routinely by PBF target hospitals	☐	Percentage	Value	0.00	0.00	80.00
				Date	03-Jan-2013	27-Oct-2014	30- May-2020
				Comment	This indicator is being revised to de-link it from "neonatal death audits".		
New	Neonatal death audits carried out routinely by PBF target hospitals	☐	Percentage	Value	0.00	0.00	80.00
				Date	15-Jan-2017	15-Jan-2017	30- May-2020
				Comment			

Revised	Health Facility Quality Index score improvement at Target PBF hospitals and facilities	☐	Average	Value	TBD[12]	TBD	65
				Date	30-Apr-2017		30- May-2020
				Comment	This indicator is being revised to de-link it from "maternal death audits".		
New	Newborns who have a postpartum contact with a health provider within 2 days of delivery in project target counties	☐	Percentage	Value	28.1	TBD	80
				Date	31-Dec-2015		30- May-2020
				Comment			
New	Physicians who complete the post-graduate medical residency program	☐	Number	Value	0.00	0.00	40
				Date	22-April-2016	15-Jan-2016	30- May-2020
				Comment			
Revised	Doctors, clinicians and other MoH-approved staff who receive hazard payment for provision of EVD-related services	☐	Number	Value	28537.00	28537.00	0.00
				Date	27-Feb-2015	27-Feb-2015	30-May-2018
				Comment	This activity is completed. Figures will therefore not change for the remainder of project implementation		
New	People who have received essential health, nutrition and population (HNP) services (millions)	☒	Number	Value	0.00	0.003	1.00
				Date	03-Jan-2013	01-Aug-2014	30- May-2020
				Comment			
Marked for Deletion	Female beneficiaries	☒	Percentage	Value	0.00	10.00	50.00
Intermediate Results Indicators							
Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target

[12] This baseline data is expected by the end of the calendar year when the results of the first verification from all project target hospitals should be obtained.

Marked for Deletion	Performance contracts negotiated and signed with target facilities, and updated annually based on modifications to the quality checklist	☐	Number	Value	0.00	0.00	6.00
				Date	18-Jan-2013	27-Feb-2015	30-May-2018
				Comment			
Marked for Deletion	Proportion of facilities that received quarterly performance-based payments based on their performance, and as per their contracts	☐	Percentage	Value	0.00	0.00	100.00
				Date	18-Jan-2013	27-Feb-2015	30-May-2018
				Comment			
Marked for Deletion	Proportion of counter-verification reports submitted to the MoH within two weeks after the end of each 6 month period	☐	Percentage	Value	0.00	0.00	100.00
				Date	18-Jan-2013	27-Feb-2015	30-Jan-2018
				Comment			
Revised	Facilities reporting no stock out of essential RMNCAH tracer drugs and commodities during quarterly quality assessment	☐	Percentage	Value	0	0	90 percent
				Date	30-May-2013	27-Feb-2015	30- May-2020
				Comment	This indicator is being revised to cover both PBF targeted facilities, as well as PHC facilities, under the rubric of "facilities". In addition, it also refines the scope to "RMNCAH" tracer drugs.		
No Change	Target PBF hospitals and CHT that achieve at least 80 percent of quarterly operational plans	☐	Percentage	Value	0.00	0.00	100.00
				Date	30-May-2013	27-Feb-2015	30- May-2020
				Comment			
Marked for Deletion	Knowledge score of residents according to key curriculum benchmarks	☐	Number	Value	60.00	N/A	75.00
				Date	18-Jan-2013	27-Feb-2015	30- May-2020
				Comment			
Revised	In-Service Training in Obstetrics, Pediatrics, Surgery,	☐	Text	Value	0	0	36
				Date	22-April-2016	27-Feb-2015	30- May-2020

	and internal medicine carried out on 6-monthly basis in project target hospitals and satellite health facilities			Comment	The target for this indicator has bee revised.		
New	Number of deliveries attended by skilled health personnel (millions)	☒	Number	Value	TBD[13]	TBD	TBD
				Date			
				Comment			
New	Children immunized (millions)	☒	Number	Value	TBD[14]	TBD	TBD
				Date			
				Comment			
No Change	Health personnel receiving training	☐	Number	Value	34	0.00	1000.00
				Date	22-April-2016	27-Oct-2014	30-May-2020
				Comment			
New	Number of new users of modern contraceptive methods[15]	☐	Number	Value	37,489		TBD[16]
				Date	31-Dec-2015	22-Nov-2015	30-May-2020
				Comment	.		
New	Priority disease events reported	☐	Number	Value	TBD[17]	TBD	TBD
				Date			
				Comment			

[13] This baseline data is expected by project effectiveness. At this time, the target will be updated accordingly.
[14] *Ibid*.
[15] This indicator will be disaggregated by methods.
[16] This indicator target will be updated by project effectiveness.
[17] This baseline data is expected by project effectiveness. At this time, the target will be updated accordingly.

New	Children under 13 years whose birth was registered in project target counties	☐	Percentage	Value	18.5	16	60
				Date	30-Sept-2016	31-Dec-2015	30-May-2020
				Comment			
New	Hospital deaths registered in a given year (for all ages) in project target hospitals	☐	Percentage	Value	0	0	75
				Date	30-Sept-2014	31-Dec-2015	30-May -2020
				Comment			
New	Grievances registered related to delivery of project benefits that are actually addressed (percent)	☒	Percentage	Value	0	0	50
				Date			30-May-2020
				Comment			

TABLE 1.2. INDICATOR DEFINITIONS

Indicator	Indicator Definition (incl. numerator and denominator)	Data Source/ Responsibility for Data collection
Maternal death audits carried out routinely by PBF target hospitals	Description: Percentage of audits conducted to ascertain cause of maternal death. Numerator: # of maternal death audits conducted and filed Denominator: Total # of maternal deaths reported	Case files and Administrative records/ Reproductive Health Supervisors & Nursing Director. PIU will collect data from responsible persons and update RF annually
Neonatal death audits carried out routinely by PBF target hospitals	Description: Percentage of audits conducted to ascertain cause of neonatal death. Numerator: # of neonatal death audits conducted and filed Denominator: Total # of neonatal deaths reported	Case files and Administrative records/ Reproductive Health Supervisors & Nursing Director. PIU will collect data from responsible persons and update RF annually
Health Facility Quality Index score improvement at Target PBF hospitals and facilities	Description: Average increase in quality index score across PBF target hospitals Quality index Score = (average process of care score + average management and structural score)	Verification Report/ National Verification Agency.
Newborns who have a postpartum contact with a health provider within 2 days of delivery in project target counties	Description: Percentage of newborns who have a postpartum contact with a health provider within 2 days of delivery in project target counties Numerator: # of newborns who have a postpartum contact with a health provider within 2 days of delivery in project target counties Denominator: Total # live births with skilled birth attendance	HMIS/HMIS Unit. PIU will collect data from responsible persons and update RF annually
Physicians who complete the post-graduate medical residency program	Description: Number of Physicians who satisfactory fulfilled all requirements to complete the graduate medical residency program.	LCPS report/ PGMC

	Total # of Residents/Physicians who completed all requirement for Specialist Physician by LCPS	
Doctors, clinicians and other MoH-approved staff who receive hazard payment for provision of EVD-related services.	Definition: Doctors, clinicians and other MoH-approved staff who receive hazard payment for provision of EVD-related services. This indicator has been added ex-post.	MOH/ PIU
Number of deliveries attended by skilled health personnel (millions)	Definition: this indicator refers to the number of women who delivered with the assistance of a skilled health provider (specialist or non-specialist doctor, midwife, nurse, or other health personnel with midwifery skills), whether in health facilities or women's homes. If project activities are mainly at health facilities, the data for this indicator can be obtained from delivery records or health management information systems. If the project activities include supporting skilled health providers to provide home deliveries, efforts should be made to accurately record such home deliveries in addition to the institutional deliveries.	MOH/ PIU
Children immunized (millions)	Definition: this indicator refers to the number of children 5 years of age and younger receiving vaccines purchased through the project, as well as the number of children immunized with vaccines purchased with other resources (i.e., GAVI or Government funds) that are delivered through the project. Importantly, it captures the number of children immunized and not the number of vaccinations; that is, if the same child is immunized with multiple vaccines on the same day or has several immunization visits in a given year, the child is counted only once. Thus simply tallying the monthly totals of the number of children receiving vaccines as recorded in immunization registers or health management information systems leads to double counting.	MOH/ PIU

People who have received essential health, nutrition and population (HNP) services (millions)	Definition: The indicator measures the number of children immunized, the number of women and children who have received basic nutrition services[18], and the number of deliveries attended by skilled health personnel.	MOH/ PIU
Health personnel receiving training (number)	Description: Number of health personnel receiving trainings and trained in areas such as Residency and in service in Obstetrics, Surgery, Internal Medicine, Pediatrics, Per service Nursing and midwifery. Basic Community health syllabus (Residency, Pre & In-service, PBF, community health trainings) The Total # of health personnel receiving training and trained = graduate residents + clinical staff who benefit from in-service and PBF training + medical students + pre-clinical students+ community assistants.	HWF TA report, LCPS / PIU
Percentage of facilities reporting no stock out of essential RMNCAH tracer drugs and commodities during quarterly quality assessment	Description: Percentage of target PBF hospitals/health facilities without stock out of essential RMNCAH, tracer drugs and commodities. Stock out is defined as Zero-Day i.e. drug is not available to the client. Numerator: # target PBF hospitals/health facilities without stock out of essential RMNCAH	Verification Report/ National Verification Agency

[18] *Women and children who have received basic nutrition services* refers to the total beneficiaries reached by any of the following services: direct feeding programs (supplementary feeding for pregnant and lactating women and infants and young children under age 5); programs promoting appropriate infant and young child feeding (e.g., promotion/support for exclusive breastfeeding, adequate and timely introduction of complementary foods); nutrition programs for adolescent girls, including nutrition education, micronutrient supplements, etc., delivered through school health/nutrition programs or other programs reaching adolescent girls; provision of micronutrient supplements to pregnant/lactating women and children under age 5 including vitamin A, iodine, iron/iron folic acid, supplemental zinc, and multiple micronutrient powders; food fortification (e.g., iodized salt); deworming; monitoring of nutritional status; nutrition and food hygiene education; nutrition components of early childhood development programs; home gardens and small livestock production for improved dietary diversity; targeted emergency food aid; and treatment of severe acute and moderate acute malnutrition. Although the same individuals could receive more than one of the above services, they should be counted only once.

	drugs, tracer drugs and commodities (as assessed through the management and structural checklist). Denominator: Total # of target PBF hospitals and facilities	
Target PBF hospitals/CHTs that achieve at least 80 percent of quarterly operational plans.	Percentage of target hospitals/CHTs that achieve at least 80 percent of the activities defined in annual business plans Numerator: # of target PBF hospitals/CHTs health facilities that achieve at least 80 percent of of quarterly operational plans. Denominator: Total # of target PBF hospitals/CHTs	Verification Report/ National Verification Agency
In-Service Training in Obstetrics, Pediatrics, Surgery, and internal medicine carried out on 6monthly basis in project target hospitals and satellite health facilities	Description: In service training sessions include the training conducted by medical faculty members and residents assigned to target hospitals consistent with in-service training plan and strategy. # of training sessions conducted	LCPS report/ PGMC
Number of new user of modern contraceptive methods	Description: New user means a person who starts a modern contraceptive method. Modern methods of contraception include: [Female condoms, IUCD, Implant/Jadell, Microgynon, Microlut].	Verification Report/National Verification Agency
Priority disease events reported	Description: Number of priority disease expected reports under active surveillance Numerator: Total # of actual reports submitted on priority disease or events Denominator: Total # of expected reports on priority disease and events	District Surveillance Officer report /Disease Prevention and Control Unit [CHA monthly report]

Children under 13 years whose birth was registered in project target counties	Description: Percentage of Children under 13 years with registered birth in a given year in project target counties Numerator: Total number of children aged Under-13 with their births registered in project target counties Denominator: Estimated population aged 0-12 years in a given year in project target counties	CRIS/ Bureau of Vital Statistics Population estimates (LISGIS)
Hospital deaths registered in a given year (for all ages) in project target hospitals	Description: Percentage of hospital deaths registered (for all ages in a given year in project target hospitals. Numerator: Total number of deaths registered in project target hospitals Denominator: Total number of deaths occurring in project target hospitals	CRIS/ Bureau of Vital Statistics

ANNEX 2. DETAILED PROJECT DESCRIPTION

1. This annex provides a detailed description of the activites that will be supported by the Project, disaggregated by Project component and sub-component. This includes the allocation of project financing, which is summarized in Table 2.1 below.

2. The overall aim of the project is to support the development of quality service delivery systems at the community, primary, and secondary levels, through the following activities: (a) performance based financing approaches at the primary and secondary levels; (b) support to the community-based health services delivery; (c) support to strengthening the country's health workforce, with a specific focus on the GMRP and in-services training; and (d) support to strengthening critical services and support Systems.

Table 2.1: Change in Project components and financing

Current Component Name	Proposed Component Name	Sub-Components	Original PAD (US$M)	FY14 Restru-cturing (US$M)	Additional Financing (US$M)	Total (US$M)
1. Strengthening the institutional capacity needed to improve the quality of selected health interventions at PBF health facilities	Support to Quality Service Delivery Systems	Sub-component 1.1: Quality Improvement of Hospitals *(revised)*	10.0	6.0	**1.2**[19]	**7.2**
		Sub-component 1.2: Strengthening primary and community-based health services to improve coverage of quality RMNCAH services *(new)*				**12.5**
		1.2.A. PBF			**6.5**	
		1.2.B. CHA			**5.0**	
		1.2.C. Adolescent Health			**1.0**	
2. Improving health worker competencies to address key health-related concerns at selected health facilities	Support to strengthening fit-for-purpose health workforce	Sub-component 2.1: Support to the Graduate Medical Residency Program *(revised)*	4.2	2.2	**0.0**	**2.2**
		Sub-component 2.2: In-service Training Programs to Mid-Level Health Cadres *(no change)*	0	0	**0.5**	**0.5**

[19] These funds are being re-allocated from sub-component 4.1 below.

3. Project Management	Project Management		0.8	0.8	**1.2**	**2.0**
4. Support to the Emergency Response to the Ebola Epidemic	Support to strengthening critical services and support Systems	Sub-component 4.1: EVD response support *(no change)*		6.0	**-1.2**[20]	
		Sub-component 4.2: Strengthening Support Functions *(new)* (a) Governance, M&E of the RMNCAH IC			**0.8**	**1.8**
		(b) CRVS			**1.0**	
		Total:	**15.0**	**15.0**	**16.0**	**31.0**

Component 1: Support to Quality Service Delivery Systems
(Original: US$10 million; after Ebola restructuring: US$6 million; This AF: US$13.7 million; total after AF: US$19.7 million).

3. This component aims to improve the quality of care at target secondary level facilities and strengthen primary and community-based health services delivery to improve coverage of RMNCAH services.

Sub-component 1.1: Quality Improvement of Hospitals

4. In an effort to improve the quality of care at target hospitals, a PBF approach will be used. Specifically, facilities will be incentive based on improvement across: (a) a defined quality checklist comprised of key indicators of interest pertaining to clinical outcomes (e.g. adherence to predefined obstetric protocols), and (b) management and sstructural aspects of services (e.g. availability of drugs and equipment and improvement in IPC). In addition, improved utilization of a pre-defined list of quantity indicators will also be incentivized. Notably, 75 percent of incentive payments to hospitals will be based on quality improvements, and 25 percent will be linked to improved utilization of incentivized services. This is an original activity, with some changes in target hospitals reflecting partners' support in the post-Ebola period. In addition, lessons learned from a completed 9-month pre-pilot at Redemption Hospital have also been incorporated.

(a) Target hospitals

[20] This represents an outstanding balance which is being reallocated to Subcomponent 1.2. In reality, since these funds were reallocated partly from component 1 for the level 1 retructuring (in August 2014), it represents a return of funds to this component.

5. Target facilities, which cover approximately 30 percent of the population of Liberia and include a mix of semi-urban and semi-rural health facilities are outlined in Table 2.2 below.

Table 2.2: Component 1.1 Target Facilities

County	District	Facility Name	Owner	Catchment Population	Type of Intervention
1. Montserrado	Greater Montserrado	Redemption Hospital	GOL	341,344	PBF/ teaching hospital
2. Bong	Suakoko	Phebe Hospital	NFP	248,300	PBF/ teaching hospital
3. Bong	Jorquelleh	C.B. Dunbar	GOL	65,316	PBF (sub-contracting)
4. Lofa	Voinjama	Tellewoyan Hospital	GOL	66,010	PBF/ teaching hospital
5. Nimba	Tappita	Jackson F. Doe Memorial Hospital (JFD Hospital)	GOL	177,285	PBF/ teaching hospital
6. Sinoe		F.J. Grante Memoriale	GOL	13,668	PBF
TOTAL				911,923	

(b) Quality and Quantity indicators

6. The quality checklist will be disaggregated into: (i) process of care; (ii) structural quality; and (iii) management performance. Table 2.3a shows the disaggregation of quality categories. This is followed in Table 2.3b by a detailed breakdown of the Process of care indicators into 14 checklists for key priority areas. Notably, the pre-pilot at Redemption Hospital highlighted the appropriateness of the checklists, albeit with some relatively minor modifications. Also, given the EVD outbreak and response, the management and structural checklist has been updated to include IPC. In addition, an international TA agency will be competively selected to support implementation and capacity building at health facilities and in key departments/ units (e.g. PBF and Quality Management units) as needed. Finally, a verification agency, which will also be competitively selected, and will be responsible for ex-ante quarterly verification of performance.

7. The quality checklist will be updated annually to reflect the shift of focus on more complex interventions across key areas of interest- maternal and newborn health, pediatrics (inpatient care), and surgical care. Notably, the weighting of indicators on clinical processes and structural indicators is expected to change over time. In particular, the quality checklist is expected to shift its weighting to more complex clinical processes, with an accompanying reduced weighting for structural indicators.

Table 2.3a: Quality Checklist Structure

Quality Categories	Indicators
I. Management	1. General Management 2. Human Resources for Health
II. Structural	3. Hygiene and Medical Waste Disposal 4. Drugs Management 5. Equipment and Supplies 6. Infection, Prevention and Control (IPC)
III. Process of Care (See below for details)	7. Aggregated Process of Care Score

Table 2.3b: Quality Checklist Structure

Checklists		
Childbirth: Maternal-Newborn	**Pediatric (in-patient care)**	**Surgical Care**
1. Obstructed Labor	8. Maternal Newborn Best Practices	14. Surgical Safety
2. Hemorrhage	9. ETAT	
3. Maternal Sepsis	10. Malaria	
4. Eclampsia	11. Pneumonia	
5. Neonatal Asphyxia	12. Acute Diarrhea	
6. Neonatal Sepsis	13. Severe Acute Malnutrition	
7. Prematurity		

Quantity indicators

8. Importantly, mitigating poor quality involves not only improving the quality of care, but also eliminating under-provision and under-utilization of essential clinical services. As such, a number of services whose utilization will be incentivized and/or sanctioned are outlined in Table 2.4. This includes, for example, major and minor surgery, and the referral of newborn children for emergency neonatal care. Primary care level services and outpatient services are excluded from the package to avoid the unwanted shift of patients from the primary level facilities to the hospital level. As with the quality checklist, this package will be updated annually as needed.

9. Associated incentives for these service delivery indicators, as well as the training indicators have been determined (and will be updated as needed) based on: a) their importance as hospital services; b) the need to minimize the inappropriate shift of patients from primary clinics and health centers to hospitals; c) sufficiency of incentives to motivate health workers; d) budget constraints; e) equity considerations (e.g. the remoteness of a hospital); and, f) feedback received during project implementation and other considerations such as faster or slower than anticipated

disbursements. Detailed information on the checklists, scoring (including the bonus allocation), use of funds, verification procedures etc. is included in the updated HSSP AF PIM.

Table 2.4: Quantity Indicators for Hospital PBF

Indicators		Definition
1	Complicated and assisted delivery (including C-section)	Any labor that is made more difficult or complex by a deviation from the normal procedure. Complicated delivery is defined as: assisted vaginal deliveries (vacuum extraction or forceps), C-section, episiotomy and other procedures.
2	Normal deliveries of at risk referrals	High-risk pregnant women referred by health center to the hospital but delivered normally. A high-risk pregnancy is defined as: evidence of edema, mal presentation, increased BP, multi-parity, etc.
3	Counter referral slips returned to health facilities	Hospital returns counter referrals letter with feedback on the referred patient to the referring health center. The counter referral letter is completed in triplicate, with one also given to the patient, and one retained by the hospital.
4	Newborn referred for emergency neonatal care treatment and treated	Newborns referred for emergency neonatal care due to: perinatal complications, low birth weight, congenital malformation, asphyxia, etc.
5	Referred under-fives with fever	Any surgical procedure that does not involve anesthesia or respiratory assistance.
6	Minor surgical intervention	Any surgery in which the patient must be put under general spinal/anesthesia and given respiratory assistance.
7	Major surgery	Patients transferred from a lower-level facility (health center or health clinic) to the hospital for emergency treatment. [21]
8	Patients transported by ambulance	
9	Number of training sessions held by faculty for nurses, midwifes and PA according to in-service curriculum and defined protocols.	These indicators will incentivize the in-service training activities.
10	Number of nurses, midwifes and PAs that received specialized in-service training, relevant to benchmarks	

Sub-component 1.2: Strengthening Primary and Community-based Health Services to Improve Coverage of Quality RMNCAH Services (new activity): this sub-component aims to

[21] Major surgery in the case of this package of services is defined as any of the following: Herniarraphy, Appendectomy, Myomectomy, Spleenectomy, Salpingectomy, Hysterectomy, Thyrodectomy, Mastectomy. It excludes CS, but includes major trauma.

strengthen PHC and community-based service delivery to improve coverage of quality RMNCAH services through: (a) a county-based contracting approach for primary service delivery and (b) support to the CHA program in remote areas . This is a key objective of the country's Investment Plan, the RMNCAH IC as well as the "Accelerated Action Plan to Reduce Maternal and Neonatal Mortality".

(1) PBF/County-based Contracting Approach for Primary Service Delivery

Overview

10. The MoH has been implementing a PBF model which is derived from a performance based contracting (PBC) approach, in which the MoH contracts out the delivery of essential primary health services to NGOs or has a 'hybrid' contract through which the County Health Teams (CHT) and NGO share responsibilities: i.e. some health facilities are managed by CHT and some by the NGO. This approach is being piloted in six counties for the past year. This project will pilot a contracting-in approach, whereby the MoH directly contracts counties to support health facilities in the provision of a package of essential health services, in three counties (Table 2.5).

11. Counties and health facilities will receive performance-based funds based on the quantity and quality of RMNCAH services (such as family planning, ANC, skilled delivery and PNC) provided in line with the RMNCAH IC priorities. The county will also be paid based on their performance against specific indicators linked to the county performance on managing and supervising the health facilities. Technical assistance by the international TA agency noted in component 1.1 above, will be provided to build capacity of the county health teams (CHTs) to ensure they are able to carry out this role, as well as at health facilities. Building their capacity in management will enhance the implementation of the IC. As much as possible, harmonized manuals and tools will be used for the different contracting approaches.

Target counties and health facilities

12. Table 2.5 below outlines the number of health facilities that will be managed by target CHTs. The target counties, Sinoe, Rivercess, and Gbarpolu, were identified as priority counties for RMNCAH IC requiring significant attention due to their remoteness; they also ranked the lowest in terms of several basic health and service indicators.

Table 2.5: Number of health facilities to be managed and catchment population

County	Managed by CHTs		Catchment population
	HC	***Health Clinic***	
Gbarpolu	0	13	84,000
River Cess	0	16	71,500
Sinoe	0	30	105,000
Total	**0**	**59**	**260,500**

Performance indicators and performance based funds

13. The MoH's PBF Operational manual for the FARA project specifies the performance indicators upon which CHTs receive funding based on the achievement of both service delivery and quality indicators as well as management indicators, under the USAID/FARA model. Health facilities will receive funding based on the achievement of service delivery indicators. While an attempt will be made to harmonize with the existing PHC indicators to the extent possible, the list of indicators that will be used under this component and details of payment approach should be finalized and validated in the first 6 – 9 months following approval of the AF. For example, in order to utilize this result based service delivery platform to promote other project components, the project will consider adding performance based indicators related to adolescent health, CRVS, IPC, etc. These will be detailed in the HSSP AF PIM.

Use of performance bonus

14. Similar to the PBF approach under sub-component 1.1, CHTs and health facilities will have a certain portion (e.g., 25 percent) of performance grant to allocate among health workers. The allocation will be made based on the performance evaluation and bonus allocation tool detailed in the HSSP AF PIM. The remaining funds will be utilized by CHTs and health facilities to further improve health facility performance, and based on their operational workplans.

Implementation arrangements

(a) **Regulator**: The regulator is responsible for the development of policy and oversight of PBF implementation, development of guiding documents and tools, and provision of technical oversight and supervision. Department of Health Services, in particular Quality Management Unit and PBF Unit will play such a role in quality assurance and PBF implementation, with the project providing logistics and other operational funds.

(b) **Purchaser**: Department of Administration in the MoH will manage the MOUs with CHTs, and hold them accountable for results.

(c) **Fund holder**: As under the original HSSP, the fund holder will be the OFM.

(d) **Implementer**: CHTs will be paid based on the performance of their health facilities (quantity and quality of services) as well as relevant performance functions. CHTs will sign performance agreements with their health facilities to incentivize them based on an agreed set of pre-defined services at the health facility and through outreach activities, as well as the quality of care. CHTs- with the support of the TA agency- in at least the first year of implementation- will be responsible for providing supervision and coaching. Finally, as per their normal role, they will be responsible for securing drugs and supplies for health facilities.

(e) **Verifier**: Independent robust verifications of reported results is critical to making PBF work. An independent organization will be procured through a competitive process, and will be responsible for carrying out ex-ante quarterly verifications. The team will visit health facilities and compare quarterly report against the patient register. The verification agency will also be responsible for assessing the achievement of management indicators for CHTs. In addition, community based organizations (CBOs) will be contracted to carry out ex-post verifications including patient-tracing on the actual use of the health facilities.

(f) **Technical assistance:** As noted above, a technical assistance (TA) agency will be procured through a competitive process, and will be partially reimbursed based on their performance against pre-defined indicators. The agency will provide expertise in PBF and in critical support functions, such as data analysis and quality improvement as well as financial management and procurement, to build the capacity of the counties and relevant actors, such as the PBF unit at central level, to carry out their role.

(2) Community Health Assistant (CHA) Program

Overview

15. In 2015, the National Policy on Community Health Services was revised to reflect the community health components of the National Health Plans 2011 – 2021 and to reflect the community health components of the Investment Plan for Building a Resilient Health System in Liberia 2015 – 2021. This revised policy includes a new cadre of CHAs selected by their respective communities. Community-based services are vital for ensuring that PHC services are available and accessible to communities located more than one hour walk (>5km) from the nearest health facility. Additionally, as noted above, the recent Ebola epidemic highlighted the critical role of involving communities in their own health-seeking behaviors. Approximately 29 percent of Liberians, and 60 percent of rural Liberians, live more than 5 kilometers from the nearest health facility[22].

16. Once trained and certified, the CHAs will be supported and supervised to deliver an integrated and standardized service delivery package, which includes curative, preventive, promotive, rehabilitative and palliative services, to households located more than one hour walk from the nearest health facility. For households located within 5km of a health facility, a tailored package of services will be delivered by other community cadres.

Scope of work for CHAs

17. CHAs will intervene at the household level. Each CHA will be responsible for providing the approved MoH integrated and standardized service delivery package to between 40 – 80 households. However, in sparsely populated areas, with walking distances greater than one hour between villages, and/or villages with a population less than 250 individuals, the minimum

[22] Liberia Ministry of Health and Social Welfare. Revised National Community Health Services Policy.

number of households will be reduced to ensure that each community has at least one CHA available.

18. As per the MOH approved service delivery packate, the roles and responsibilities of CHAs include, *inter alia*, (i) household visits at least once a month, (ii) referral of cases to health facilities and follow-up, (iii) community death recording and community disease surveillance and control, (iv) home-based health services including family planning, antenatal care (such as distribution of misoprostol, pre-natal vitamins, insecticide treated nets, malaria treatment), postnatal care (such as preventive misoprostol, vitamin A administration), neonatal care, and vaccination drop-out tracing, (v) first aid and basic life-saving skills (BLSS), and (vi) integrated community case management (iCCM) for malaria, ARI and diarrhea with bi-directional referral system, including financing of CHA Costs, and (vii) health and hygiene promotion, and environmental sanitation. CHA costs that will be covered include a base monthly compensation of seventy USD$70, together with non-monetary incentives: transportation, gifts in-kind, involvement in national campaigns, and recognition events.

19. Further, as defined in the National Community Health Services Policy, as a part of the CHA program, the AF will also support community activities, including: (i) identification and prioritization of relevant RMNCH problems; (ii) detection, referral, and reporting of suspected diseases of epidemic potential; (iii) community health interventions, including IPC and community-led total sanitation (CLTS); (iv) support for treatment adherence and stigma reduction for priority diseases; and (v) mobilization of local resources to support health interventions. In addition, community representatives and civil society groups will be supported to participate in planning, implementing, monitoring, and feedback through community health committees (CHC) and health facility development committees (HFDCs) and Hospital Boards. Areas of financing through the HSSP AF will be in line with the CHA Policy, including: monetary compensation, non-monetary motivation, training, supplies, transport and logistics, supervision, M&E, etc.

20. The EERP supports the roll-out of CHA activities in 8 counties (5 rural unaddressed South East counties through UNICEF and 3 prioritized counties in the HWP with rural population and high disease burdens through a contracted NGO). This is also geographically coordinated with a USAID program that rolls out the same package of activities in six counties. This proposed AF will take over a number of yet-to-be-determined prioritized counties from the EERP and improve approaches based on lessons learned. As under the EERP, an NGO may be contracted by the MoH to assist with managing the implementation of this sub-component and build capacity of relevant stakeholders.

(3) Adolescent Health

21. In addition to these supply-side community, primary and secondary care interventions that integrate adolescent and adolescent responsive RMNCAH services (e.g., SRH/family planning services to young mothers, STI/HIV prevention and management including HIV testing and counselling, post-abortion care services), a funds will be earmarked to finance operational and consultant cost for the MoH to carry out demand-side prioritized adolescent health activities in selected counties focusing on teenage pregnancy. These include: school health programs, and

community engagement including youths to increase awareness and impact of gendered decisions on adolescents' well-being. The precise activities to be funded under this component will be detailed in the PIM.

Component 2: Support to Strengthening Fit-for-Purpose Health Workforce
(Original: US$4.2 million; after Ebola restructuring: US$2.2 million; this AF: US$0.5 million; total after AF: US$2.7 million).

22. Consistent with the orginal design under the HSSP, this component will support the country's health workforce program in an effort to improve health worker competencies to address key health-related concerns, with a specific focus onthe following: (a) the GMRP; and (b) in-service training.

Sub-component 2.1: ***Support to the Graduate Medical Residency Program (GMRP)*** (Original activity).

23. This component will support GOL's ongoing effort to develop and implement an innovative GMRP to increase the number of physicians with certified skills in critical specialist areas - obstetrics, pediatrics, general surgery and internal medicine. Specifically, the Project will finance: (i) recruitment of specialized (core and subspecialist) teaching faculty in the areas of pediatrics, obstetrics, internal medicine and general surgery; and provision of training and accommodation to residents at targeted semi-urban and semi-rural health facilities; (ii) deployment of medical and coaching staff to the target teaching hospitals; and (iv) (limited) renovation of existing accommodation spaces in existing facilities and funding of reasonable accommodation costs for medical/ teaching staff, faculties and residents. This component will support the residency program, which is designed to shift the training of residents away from the Capital- Monrovia (after initial commencement of the residency in Liberia's only tertiary teaching hospital, JFK)- to semi-urban (Margibi and Bong County), and (importantly) semi-rural counties (Lofa, Nimba and Maryland County). The GMRP will be nationally accredited, although the Program will work towards regional West African Health Organization (WAHO) accreditation standards in the medium-term. The Liberia College of Physicians and Surgeons (LCPS), the governing and administrative body of the GMRP, will be supported in this process by professional bodies in the sub-region (for example, WAHO, and the West African College of Physicians and Surgeons).

24. As mandated by the residency program requirements, the component will support resident rotations between the hospital, semi-urban specialized hospitals, and semi-rural affiliated teaching sites. Following an initial 6 months training in the hospital, residents will be mandated, to carry out alternating 6 month rotations between the hospital and semi-urban specialized hospitals, before spending their final 6 months residency back in JFK. The rotational arrangement will shift both the numbers of physicians and training arrangements from traditionally urban to more rural sites. Funding under this component will include support towards accommodation costs of residents, where no accommodation can be provided by the target facility.

Sub-component 2.2: In-service training programs to mid-level health cadres

25. This subcomponent will leverage the teaching capacity made available under sub-component 2.1 to provide specialized training in critical specialist areas to mid-level cadres (midwives, nurses, and PAs) in target hospitals as well as satellite health centers. This will address a key concern that health workers across all cadres are insufficiently receiving both in-service training and opportunities for continuous professional development (particularly in the areas of obstetrics, pediatrics, internal medicine and general surgery). This negatively affects their competencies and motivation, and ultimately service delivery outcomes.[23] This AF allocates US$0.5 million to this critical activity. The expectation under the HSSP was that this would have been funded through PBF incentives; the scale-up of which, as noted above, has been delayed.

26. Specifically, the faculty recruited and placed in target facilities (under the residency program), along with senior residents, will be mandated contractually to carry out training sessions to clinical health workers in both the intervention hospitals where they are stationed, as well as in satellite health centers (located in the hospital catchment areas) as part of mandated community outreach. Notably, in close alignment with the PBF mechanisms under sub-component 1.1, hospital managers will be incentivized to ensure that a relevant number of training and outreach sessions are carried out. Training will conform to a number of innovative and new, but also well tested and frequently utilized formats; this will include Team Training Sessions, Grand Rounds, Practical Clinical Training Sessions, Team-based Teaching & Learning, IT-moderated skill labs, and workshops focusing on particular specialized topics.

27. Over the project implementation period, an estimated 45 percent of mid-level cadres will receive continuous professional development training in key relevant competencies linked to obstetrics, pediatrics, surgery and internal medicine by (inter alia) faculty and in-training residents**.** This includes (80- 100 percent of) staff at both the 6 project target facilities, and satellite health centers, through the mandated outreach to be provided.

Component 3: Project Management
(Original: US$0.8 million; after Ebola restructuring: US$0.8 million; this AF: US$1.2 million; total after AF: US$2.0 million).

28. This component will support the operational capacity of the MoH to effectively manage the Project (original and AF). This will include support to the operational costs of the PIU within the MoH, that will be responsible for coordinating project activities. The MoH decided to integrate the PIU for the EERP and the PCO for the HSSP approximately one year ago, in an effort to improve alignment and sequencing of activities under the two projects. A staffing plan has been developed for the PIU. In addition, this component will also support other Departments within the MoH as needed to improve capacity to manage and monitor implementation of RMNCAH activities at the national and sub-national levels.

Component 4: Support to Strengthening Critical Services and Support Systems
(Original: US$6 million; this AF: US$1.8 million; total after AF: US$7.8 million):

[23] National HRH Plan, 2011-2021

29. This component provides funds for critical services- in response to the EVD outbreak and response, and supporting functions including infrastructure required to ensure quality RMNCAH services.

Sub-component 4.1. EVD Response Support

30. This sub-component, developed through the HSSP restructuring, supported Liberia in building its EVD crisis emergency response system. This sub-component is fully disbursed, with planned activities completed. This included providing infection and prevention control (IPC) materials and vehicles to allow proper responsiveness to crisis situations. Also, in an effort to ensure health services delivery, and in effect, support the functioning of the overall health system, Ebola response workers and health workers in regular health facilities received monthly hazard pay (risk allowance) to incentivize them to engage in both the Ebola response and regular health service delivery activities. No changes are being made to this sub-component under this AF. Approximately US$1,277,000, which was unspent as EERP took over majority of Ebola financing, will be returned to the original activity of 1 hospital PBF in Sub-component 1.

Sub-component 4.2. Strengthening Support Functions (New Activity)

31. This is a new sub-component which aims to strengthen supporting functions for quality RMNCAH service delivery and the health workforce program. This sub-component provides support to CRVS (US$1million) and M&E systems (US$0.8 million).

(1) Governance, Monitoring and Evaluation of the RMNCAH IC

32. This subcomponent will directly support the country platform needed to ensure the implementation and monitoring of the RMNCAH IC. Specifically, the AF will provide support to the Health Services Division at the MOH and the Planning and Research Department, which is expected to take a leading role in this process, along with relevant technical working groups as needed. These include, the Reproductive Health Technical Committee (RHCT) for service delivery, the supply chain technical working group, health financing technical working group, Human Resources for Health technical working group and the community health service delivery technical working group. In addition to this, and as part of its efforts to ensure that the implementation of the IC is adequately monitored and evaluated, the project will also support data collection, analysis and evaluation efforts, both on an ongoing basis, and at specific milestones during implementation, in order to ensure quality assurance, and mid-course corrections as needed. The precise activities to be funded under this sub-component, including the roles and responsibilities of the various stakeholders, and the distribution of funding, will be detailed in the PIM.

(2) Civil Registration and Vital Statistics [24]

[24] Civil registration, which refers to the registration of births, deaths (and certifying cause of deaths), marriages, and divorces, provides data for the production of vital statistics. A complete and accurate CRVS system provides disaggregated data at the national and sub-national levels for the planning and monitoring of health programs, but

33. This subcomponent will support the implementation of 2016-2020 CRVS investment plan aligned to the RMNCAH IC. The focus of this support will be on improving birth and death registration services beginning in three RMNCAH target counties. Prioritized interventions and activities that will be taken from the following menu, with the agreed inteventions indicated in a workplan which is expected shortly:

(i) *improving birth registration services* – the project will support the development, and institutionalization of a uniform birth registration form and birth certificate, taking into consideration the two co-existing birth registration systems; develop and implement a plan for using immunization process to boost birth registration; develop training manuals and train relevant staff at the County and District levels; conduct information, education, and communication (IEC) campaigns; procure motorcycles, and office equipment (including laptops, Internet modems and subscriptions).

(ii) *improving death registration services* – develop and implement a detailed costed plan for death registration (and for determining causes of deaths) for deaths at health facilities and maternal death reviews (based on activities in the CRVS IC). This will complement the ERRTF-funded Strengthening Liberia Health System Project's (P158005) focus on maternal death and surveillance system (MDSR) which is being implemented by UNFPA. A critical aspect of this activity will be rolling out, and institutionalizing systematic death audits and associated causes of death, at health facilities and ensuring these deaths and their causes are registered in the CRVS system.

(iii) Civil Registration (CR) information system development, including CR management information system, birth registration management information systems, and Training;

(iv) technical assistance for strengthening legislation; Training and carrying out of awareness campaigns, and financing supervision costs of CR workers;

(v) *strengthening legislation and raising awareness and advocacy* - review CRVS laws (Executive law of 1972, 1976 Public health law, 2008 Children's law, 1973 new domestic law, etc) to make recommendations for amendment, where necessary and raise public awareness.

(vi) *providing human resources* – in order to ensure that the civil registration system is effective and functional, a number of existing staff will need to be trained, and additional staff may need to be recruited. To the extent possible, however, and in order to ensure sustainability of interventions under this sub-component, existing staff and implementation arrangemnts will be used to the extent possible. That said, it is possible that a number of District Registrars may need to be recruited as part of the District Health Management Teams for both births and deaths registration along with data entry clerks.

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also has important benefits beyond the health sector (e.g. CRVS serves as a foundation for the issuance of passports, national identification cards, social security cards, drivers' licenses, and voters' registration cards).

(vii) Support for national *coordinating national efforts and project management* – a critical element in ensuring that the CRVS system is functional and effective, is instituting a CRVS national multi-stakeholder steering and coordination committee to coordinate the implementation of the IC. This Committee should involve, inter alia, the following key actors: MoH, Ministry of Education, Ministry of Gender and Social Protection, MIA, Center for National Documents and Records Agency/National Archives, the Civil Law Court, and Liberia Institute for Statistics and Geo-Information Services).

ANNEX 3: PARTNER MAPPING ACROSS THE RMNCAH IC PRIORITY AREAS

RMNCAH IC priority Areas	Sub areas	USG support	Other partner support	Other World Bank support	Major Gaps this project will support
1. Quality EmONC	• Health worker • Infrastructure • Medical supplies • EmONC service • RMNCAH primary health delivery • Community health	• TA, faculty, equipment for selected training institutions • Warehouse infra and procurement and supply chain support • Primary PBF support and CHA program in three countries in Lofa, Bong, Nimba	• GFATM to support to 7 training instution and Nursing Master's program • Gavi to support cold chain • Health promotion and community empowerment programs in Bomi, Lofa, Nimba • GIZ to cover infra, health facility support in South East counties	• EERP and original HSSP to cover gaps in physician, nursing and midwifery training. • EmONC support to 8 target health facilities • Original HSSP support hospital PBF including EmONC • EERP to support the launch of CHA program in Rivercess, Gbarpolu, Grand Cape Mount, South East Counties	• Primary PBF support in target facilities in priority counties • CHA program roll out and continuation in priority counties
2. CRVS Sytem	• Improve birth registration • Improve death registration • Civil registration information systems • Legislation and advocacy	• Potential incentives to birth and death registration through primary PBF	• UNICEF support for birth registration • Plan Liberia for advocacy in birth registration		• Targeted activities in CRVS investment case • PBF to target health facilities to incentivize birth and death registration.
3. Adolescent	• Support	• Strengthening	• EC support		• Targeted activities to

Health	during antenatal, childbirth, postpartum periods • Unsafe abortion • Gender-based violence	FP- Youth-friendly services, school health, collaboration with youth leaders • PBF incentives to promote adolexcent heph	against gender-based violence		pilot high-impact interventions. • PBF in target primary facilities to incentivize the use of modern FP methods.
4. Preparedness, MDSR	• IDSR including CEBS • MNDSR	• Support to CHA program on CEBS in the 3 counties	• GIZ to support IDSR in South East counties • EC to support border surveillance	• Comprehensive IDSR support through REDISSE • MNDSR support in selected 8 facilities (ERRTF)	• PBF at target hospitals to incentivize MNDSR.
5. Community Engagement	• CHA program • Civil society involvement	• CHA program in the 3 counties • Communiry monitoring of PBF facilities	• Potential support by Gavi, GIZ	• Initial set-up of CHA program through EERP. • Community support in selected facilities (ERRTF)	• Continuation of CHA program in priority 3 counties initially supported by the EERP.
6. Leadership, Governance, Management	• Strengthen family health division • RMNCAH IC monitoring, accountability	• TA support to MoH and the 3 counties		• Support to PIU and other MoH Departments	• Support to family health department for monitoring of RMNCAH IC • TA to counties and hsopitals on areas of management, planning, monitoring etc