INTEGRATED SAFEGUARDS DATA SHEET
CONCEPT STAGE

Report No.: ISDSC747

Date ISDS Prepared/Updated: 06-Feb-2013

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I. BASIC INFORMATION

A. Basic Project Data

Country:	Liberia	**Project ID:**	P128909
Project Name:	Liberia Health Systems Strengthening (P128909)		
Task Team Leader:	Rianna L. Mohammed-Robert		
Estimated Appraisal Date:	19-Feb-2013	**Estimated Board Date:**	30-May-2013
Managing Unit:	AFTHW	**Lending Instrument:**	Specific Investment Loan
Sector:	Central government administration (10%), Health (90%)		
Theme:	Health system performance (45%), Population and reproductive health (35%), Child health (20%)		

Financing (In USD Million)

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	10.00
Health Results-based Financing	5.00
Financing Gap	0.00
Total	15.00

Environmental Category:	B - Partial Assessment
Is this a Repeater project?	No

B. Project Objectives

14. The Project Development Objective (PDO) is to “improve the utilization and quality of medical interventions under the EPHS in target counties”. Medical interventions are expected to focus largely on MDGs 4, 5 and 6. While pregnant women and children are expected to especially benefit from this project, project beneficiaries include all who seek health care services at secondary and primary-level facilities through: performance-based incentives at the secondary level; incentives to improve

the referral chain; and, support to improving health-worker skills and competencies. This project is expected to be implemented over a 4 year period (June 2013 – June 2017).

C. Project Description

2. The proposed Liberia Health Systems Strengthening Project aims to strengthen the institutional foundations of the health sector needed to improve MDG 4, 5, and 6 related health outcomes. Specifically, the project aims to improve these health-related MDGs and specific MCH outcomes at the secondary level by improving supply side conditions through: (a) improving health worker motivation (through PBF); (b) improving accountability mechanisms (related to both the achievement of results, and health-worker behaviors) at secondary-level facilities; (c) improving the availability of: qualified graduate physicians (pediatricians, obstetricians, general surgeons and infectious diseases internists); (d) improving the competencies of lower level health worker cadres – including nurses and midwives and assistants- in emergency obstetrics, surgery, pediatrics, and infectious diseases; (e) upgrading appropriate clinical and medical training equipment and clinical training infrastructure; (f) improving access to essential drugs (through PBF); and (g) strengthening the referral chain from the primary to secondary-level facilities. These improvements should provide a thrust towards demand-side utilization, and outcomes.

3. Specifically, component 1 will strengthen and advance the current contracting-in approach, in which County Health and Social Welfare Teams (CHSWTs) are responsible for supporting health facilities to achieve results and in-turn are remunerated based on their performance (i.e. the achievement of results). Under a PBF approach, health facilities will develop their business plans to improve utilization and quality at their facilities, implement business plans while providing services, receive financial incentives directly based on their performance and results, and manage the funds received for further improvement of their services (including those directly and indirectly emanating from improved training/teaching by medical residents and faculty to nurses, midwifes and outreach workers at rural decentralized clinical facilities). As such, there is emphasis on both strengthening separation of functions and verification to avoid misreporting; and providing rural and more remote health facilities with sufficient autonomy to manage funds. Notably, incentives can be used to address supply-side gaps (e.g. health facility operational and capital costs, support to training, and health worker motivation).

4. Component 2 will complement efforts to improve MDG 4, 5, and 6 outcomes under component 1 by focusing on addressing the existing gaps in health worker competencies (in obstetrics, pediatrics, surgery and infectious diseases), through: a) developing and implementing an innovative Graduate Medical Residency Program (GMRP) for physicians (in selected clinical teaching facilities), with mechanisms to facilitate the transfer of skills from residents to frontline health workers (for example nurses and midwives in rural health facilities) as part of residency requirements, and; b) simultaneously strengthening specialized technical/teaching as well as physical capacity in teaching hospitals and affiliated rural institutions (used for the GMRP).

Component 1: Improving the coverage and quality of Key MDG 4, 5, and 6 related services through PBF at Secondary levels of care (US$10 million)

5. In recognition of the focus of significant external funds on primary health care (health clinics, and lower level service delivery points) and challenges in the proper-functioning of the referral chain, Component 1 will focus on delivery of the EPHS through PBF at (targeted) secondary level facilities- hospitals and health centers run by government and non-profit agencies- with

supervisory and referral links to the primary level. This approach will provide a financial subsidy directly to service providers contingent upon delivery of services defined in the EPHS. This component will be rolled out in a phased approach (i.e. pre-pilot and larger roll out), and will involve both investments (PBF incentives) and technical assistance (where needed). Technical assistance will focus on strengthening capacities (e.g. institutional capacity- at all levels of the health system, and CHSWTs- for PBF), and the development of a robust M&E system. This component is organized into two sub-components: a) Performance-based contracts with secondary-level facilities ($8.5 million); and, b) Management and Capacity building PBF ($1.5 million).

Component 2: Improving health worker competencies to address MDG 4, 5, and 6 related concerns (US$4.2 million)

6. Whereas PBF is expected to narrow the gap between what health workers know how to do, and actually do (by motivating them to perform better), further performance improvements are dependent on an increase in the quality/competency of health workers with sufficient skill sets in MDG 4, 5, and 6 relevant areas. Interventions under this component will not just benefit graduate physicians, but also provide targeted and needs-based training to lower level health workers in the teaching hospitals and affiliated rural secondary institutions (i.e. the 19 intervention facilities), through improving the quality of existing clinical leadership particularly in predefined critical areas of Emergency Obstetrics, Surgery, Pediatrics, and Infectious Diseases.

7. The lack of a well developed, high quality and innovative medical residency programs in Liberia, in part because of the insufficient training capacity (in terms of specialized faculty), and weak physical capacity at teaching hospitals and affiliated institutions, have prevented medical school graduates from undertaking an accredited medical residency program – in emergency obstetric, pediatrics, surgery and infectious diseases (in urban and rural teaching hospital and affiliated institutions). The lack of a formal residency program, with mandatory rotations of residents to rural health facilities, has also limited the possibility of increasing (albeit temporarily) the number of higher skilled providers in more rural facilities, and of transferring needed basic but life saving skills (linked to obstetrics, surgery, pediatrics and infectious diseases), to front line health workers, particularly in rural areas. Short term training and upgrading of skills of all health workers can be provided not just by the expert faculty (which this component will develop), but also by the medical residents themselves during their residency rotations. In recognition of these challenges and opportunities, the project will support the government through the following two sub-components: a) Design and Development of a Progressive Graduate Medical Residency Program (GMRP) to benefit both residents and front line health workers; and, b) Enhancing the Technical and Physical Capacity of the Teaching Hospitals and secondary level partner facilities to provide relevant training under the Medical Residency Program.

Component 3: Project Management (US$.8 million)

8. This component will support the operational capacity of the MoHSW to effectively manage the project. This will include support to the operational costs of a project- specific unit within the MoHSW (Project Management Unit) that will be responsible for coordinating project activities.

D. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

10. Component I of the project will be implemented in seven pre-defined counties. Improvements under component II is expected to benefit all counties in Liberia.

11. The project triggers OP/BP/GP 4.01 - Environment Assessment. The project is financing drugs and medical supplies that trigger safeguard policies related to medical waste management. Renovating or extending teaching facilities and associated reconstruction of teaching lab space, and resident quarters also requires that an environmental safeguards management plan be put in place to mitigate the possible negative impacts. No new construction will be financed. There will be training which will further enhance the understanding and therefore compliance with the triggered safeguards policy and follow-up instruments to be prepared.

E. Borrowers Institutional Capacity for Safeguard Policies

12. The Government prepared an Environmental and Social Management Framework (ESMF) which included a Medical Waste Management Plan under the recently closed Health Systems Reconstruction project. This will be updated. The ESMF for the project will make adequate recommendations regarding capacity building needs, training, budget and awareness building to ensure its proper and effective implementation.

13. The safeguard-related documents will be disclosed before appraisal (i) at the InfoShop and (ii) in country, at publicly accessible locations and in a form and language that are accessible to potentially affected persons.

14. The Borrower has insufficient institutional capacity for safeguards implementation. During implementation of the project, several staff will be trained in medical waste management. These will include district medical officers and environmental health officers and environmental officer of the local councils. In addition, NGOs and some public, private and paramedical health care staff will also be trained in medical waste management. Technicians will also be trained on how to operate medical waste management equipment (including incinerators) and guidelines will be distributed for medical waste management. The training will use the Medical Waste Management Plan and the ESMF and other relevant documents. The Recipient will be charging the Environmental and Sanitation Unit (ESU) of MOHSW to ensure that all health facilities in the country manage health care waste in full compliance with this plan. A number of health facilities under the project will have to construct incinerators which are not operational and effective.

F. Environmental and Social Safeguards Specialists on the Team

Paula F. Lytle (AFTCS)

Moses Yao Duphey (AFTN3)

II. SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/ BP 4.01	Yes	The project has the potential to increase medical waste from health facilities. Unregulated disposal of bio-hazardous waste can constitute a serious environmental and social issue in Liberia. Renovating or extending teaching facilities and associated reconstruction of teaching lab space, resident quarters also requires that an

		environmental safeguards management plan be in place to mitigate the possible negative impacts.
Natural Habitats OP/BP 4.04	No	The project is not taking place in or near natural habitats.
Forests OP/BP 4.36	No	The project does not involve forests.
Pest Management OP 4.09	No	The project does not involve the use of pesticides or pest management schemes.
Physical Cultural Resources OP/ BP 4.11	No	The project does not involve or affect physical cultural resources.
Indigenous Peoples OP/BP 4.10	No	There are no Indigenous Peoples in the project area.
Involuntary Resettlement OP/BP 4.12	No	This policy is not triggered since the project activities do not require any land acquisition that would lead to involuntary resettlement and/ or restrictions of access to resources and livelihoods. Rehabilitation works are minor and within the footprints of existing facilities. There is no encroachment near or at these facilities.
Safety of Dams OP/BP 4.37	No	N/A
Projects on International Waterways OP/BP 7.50	No	N/A
Projects in Disputed Areas OP/BP 7.60	No	N/A

III. SAFEGUARD PREPARATION PLAN

A. Tentative target date for preparing the PAD Stage ISDS: 15-Nov-2012

B. Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing[1] should be specified in the PAD-stage ISDS:

The existing ESMF (which includes the HCWM) will be updated during project preparation. The Ministry of Health and Social Welfare (MOHSW) and the Project Management Unit (PMU) will work closely to monitor implementation of the HCWM plan by health facilities during project implementation. The Bank team will follow up on this during supervision visits.

IV. APPROVALS

Task Team Leader:	Name: Rianna L. Mohammed-Robert	
Approved By:		
Regional Safeguards Coordinator:	Name: Alexandra C. Bezeredi (RSA)	Date: 06-Feb-2013
Sector Manager:	Name: Trina S. Haque (SM)	Date: 03-Oct-2012

[1] Reminder: The Bank's Disclosure Policy requires that safeguard-related documents be disclosed before appraisal (i) at the InfoShop and (ii) in country, at publicly accessible locations and in a form and language that are accessible to potentially affected persons.