

**PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE**

Report No.: 93862

Project Name	Supporting Psychosocial Health and Resilience in Liberia
Global Practice	Health Nutrition and Population
Country	Liberia
Sector(s)	Health (100%)
Theme	Health System Performance (20%), Child health (40%), and Injuries and NCDs (40%).
Lending Instrument	Project Investment Financing
Project ID	P146591
Borrower(s)	N/A
Implementing Agency	The Carter Center
Environmental Category	C- no assessment
PID Prepared/Updated	December 8, 2014
Date PID Approved/Disclosed	December 17, 2014
Estimated Date of Board Approval	N/A
Decision	
Other Decision	

I. Project Context

Country Context

1. Ten years after the end of the civil war, Liberia remains a fragile state and one of the poorest countries in the world. Despite robust annual growth of 8.3 percent in 2012, the gross national income (GNI) per capita is only US\$370, far below the average for other low-income countries in Sub-Saharan Africa (SSA). More than one-half (56 percent) of the population lives below the national poverty line, and approximately 80 percent live below the international poverty line of US\$1.25 per day.ⁱ Despite gains in recent years, improving human development outcomes in Liberia continues to be challenging. In 2013, Liberia ranked 174th out of 186 countries on the Human Development Index (HDI) with a score of 0.388. The score is significantly lower than the SSA average.ⁱⁱ Average life expectancy in Liberia is 60 years and the adult literacy rate is 60.8 percent.ⁱⁱⁱ

2. Liberia is currently experiencing the worst Ebola Virus Disease (EVD) outbreak in history. According to the Center for Disease Control and Prevention (CDC), the total case count (confirmed, probable, and suspected) in the country has reached 4,249, and the total number of deaths from Ebola has reached 3,161 as of December 8, 2014. The EVD crisis has significantly overstretched an already weak health system, with far-reaching impact on all sectors of the economy. Liberia's gross domestic product (GDP) growth, for example, is expected to decline from 5.9 percent growth to 2.5 in 2014^{iv}.

Sectoral and Institutional Context

3. Liberia has made notable progress in health systems management and health services delivery over the last decade. Progress has been especially evident in the areas of maternal and child health (MCH), although gains remain skewed in favor of urban populations. The maternal mortality ratio (MMR) has declined from close to 1,000 per 100,000 births in 2007 to an estimated 770 per 100,000 births in 2010.^v Infant and under-five mortality rates have also decreased significantly from 144 and 220 per 1,000 live births to 73 and 75 per 1,000 births, respectively, over the last 25 years.^{vi} Over one in ten children, however, still dies before the age of five, and the country continues to face significant challenges in further improving maternal and child health outcomes, as well as other health-related Millennium Development Goal (MDG) outcomes.

4. Available research shows that mental health and psychosocial issues affect a large portion of the population in Liberia. However, to date, they have received limited attention.¹ Such issues largely stem from the civil war which lasted from 1989 – 1997 and 2001 – 2003, during which a significant portion of the population experienced various traumatic events. A 2008 study, for example, found that 40 percent of the Liberian population self-reported symptoms characteristic of major depression, and 44 percent noted indications associated with post-traumatic stress disorder (PTSD).^{vii} The 2010 Global Burden of Disease has also revealed that mental disorders in Liberia account for more disability-adjusted life years than any other non-communicable disease.^{viii} Scientific evidence has found linkages between these and other mental disorders and reduced functioning and engagement in high-risk behaviors (e.g., substance abuse and interpersonal violence). Left untreated, they can hinder an individual's ability to fully and productively participate in daily life which can have important consequences for a country such as Liberia which relies on the population for its short- and long-term recovery. In addition to the individual-level impact, available research points to the impact of traumatic events on both community and family ties.

5. Recognizing the importance of addressing the psychosocial and mental health needs of its population, the GOL developed a National Mental Health Policy (NHMP) in 2009. The NHMP prioritizes an integrated and decentralized approach to the delivery of mental health care and focuses on the following objectives: (i) prevention of mental illnesses; (ii) improved accessibility and availability of psychosocial and mental health services; (iii) provision of services for particularly vulnerable groups; (iv) provision of rehabilitative services and; and (v) the provision of social services. Achieving these objectives through a community-based approach is one of the pillars of the GOL's strategy to address the mental health and psychosocial needs of the population.

6. Operationalizing the NMHP, however, has proven to be a challenge. The supply of psychosocial and mental health care and services in the country has been inadequate to meet the significant demand. This gap is largely due to an insufficient number of trained mental health care workers and a general lack of resources to cover the costs associated with mental health prevention and treatment. In an environment with significant funding gaps, it is notable that a few non-governmental organizations (NGOs) including The Carter Center (TCC), Médecins du Monde, the Center for Victims of Torture, the Peter C. Alderman Foundation, and Urgent Action

¹ Psychosocial support is a process of facilitating resilience within individuals, families and communities. This approach respects the independence, dignity and coping mechanisms of individuals and communities, while promoting the restoration of social cohesion and infrastructure. The World Health Organization (WHO) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community”.

Fund-Africa (UAF) have provided important support in this area.²

Current Situation: The Ongoing EVD Crisis

7. The EVD outbreak and some measures carried out under the emergency response are expected to have a negative impact on the mental and psychosocial health of the population. Preliminary reports from the field have highlighted the toll of the EVD outbreak on community and individual psychosocial well-being. The observed high levels of stress as well as individual and community grief reactions are a result of the fear and major loss which has occurred as a result of the EVD outbreak. Together, the heightened fear and suspicion, the loss of family and friends, as well as the inability to mourn the deceased according to traditional and religious rituals, is causing the population further stress and has the potential to exacerbate previously unaddressed poor psychosocial and mental health. On the individual level, research shows that unmitigated trauma in many instances leads to negative coping behaviors (e.g., substance use and poor self-care), a limited sense of agency (self-efficacy), and hopelessness about the future. On the community level, the trauma can manifest in a lack of collective efficacy, a general mistrust of formal institutions, and a reduction in social cohesion. These feelings and behaviors have, in part, contributed to the continued transmission of the disease and have torn the fabric of communities.

8. Staff at Ebola Treatment Units (ETUs) and Community Care Centers (CCCs), and burial teams (“first responders”) are in particular need of psychological care and support. In addition to confronting suffering and death on a daily basis, they face serious stigma in their own communities. The high levels of stress, grief, and fear they consequently experience can lead to reduced adherence to infection prevention and control protocols (including the appropriate use of personal protective equipment), which can thus increase their risk of infection and of continued disease transmission. Additionally, in the face of stress, some first responders have reportedly resorted to maladaptive coping behaviors including excessive alcohol use.

9. The project aims to address the psychosocial health impact of the EVD outbreak at both the individual and community levels, whilst also building long-term resilience and psychosocial health. Its technical design emphasizes the role of strengthening protective factors as a means of promoting resilience. Resilience refers to good mental health and developmental outcomes despite exposure to significant adversity.^{ix} Individuals who are resilient are more likely to demonstrate an adaptive stress response, have the ability to recover rapidly from stressful events, and be less susceptible to stress-related psychopathologies and poor mental health.^x Resilience is not only by an individual’s attributes, but also by their interactions with the broader environment, such as those with family, peers, school/work, community resources, and social structures and institutions.^{xi} These interactions can have either a detrimental or positive effect on the development of an individual’s capacity to cope and recover despite adversity.^{xii} Further, protective factors (e.g., a supportive environment, positive relationships with family and peers, and avoided exposure to violence) can buffer the detrimental effects of living in a precarious and challenging setting on an individual’s well-being.^{xiii,xiv,xv}

10. This project will be implemented using a community-based approach. The project will work closely with the communities themselves and indigenous healers (including traditional and religious leaders) to support and strengthen existing community- and family-based practices to

² TCC, for example, has trained 144 mental health clinicians (i.e. nurses and physician assistants), and UAF is implementing community dialogues that focus on building community resilience and decreasing stigma around mental health.

increase protective factors and reduce stressor factors with the aim of promoting resilience and recovery. Further, the proposed project's design and objectives are well-aligned with the GOL's Psychosocial Response Strategy and Procedures Addressing the Needs of Persons, Families and Communities Affected by Ebola in Liberia.

II. Project Development Objective(s)

11. **The Project Development Objective (PDO)** is to respond to the intermediate psychosocial/mental health impact of the EVD crisis and to build long-term psychosocial health and resilience at the individual and community levels in defined project target areas. The PDO will be achieved through: (i) the training and capacity building of new and existing cadres of mental health providers (i.e. mental health clinicians [MHCs], psychosocial counselors, social workers, and general community health volunteers [gCHVs]); (ii) the implementation of psychosocial/mental health interventions at the individual/ family and community levels; and (iii) supporting project management, and monitoring and evaluation, which will help to guide project implementation.

III. Project Description

12. The project consists of three components. Component 1 responds to the intermediate psychosocial/mental health impact of the EVD crisis through the implementation of a set of psychosocial interventions aimed at addressing grief, trauma, and stigma at the individual and community levels. Component 2 aims to build resilience and long-term psychosocial health, by focusing on factors that promote and engender trust, efficacy, and acceptance of those with mental health issues at the individual and community levels. Psychosocial interventions, which enhance resiliency and health promotion for vulnerable groups (including mothers, children and adolescents), will also be designed and implemented. Project interventions, therefore, will have a direct impact on improving maternal and child health in Liberia. Component 3 involves project monitoring, evaluation and management.

Component 1: Support for Intermediate Psychosocial/ Mental Health Impact of the EVD Crisis (US\$0.51 million)

13. Component 1 will respond to the intermediate psychosocial/mental health impact of the EVD crisis through the implementation of psychosocial and capacity-building interventions at the individual and community level. These interventions are designed to reduce depression, PTSD, and disability among project beneficiaries; decrease stigma against EVD-affected individual/households; increase levels of trust at the community level; and increase the level of competence, skills and confidence of these various providers. Specific activities that will be carried out under these psychosocial and capacity-building interventions include: (i) Individual counseling activities encompassing a range of evidence-based approaches (i.e. cognitive-behavioral therapy, interpersonal therapy, talk therapy; problem-solving techniques, active listening, and counseling for trauma and grief and loss); (ii) Group counseling led by MHCs and/or social workers consisting of condition- or topic-focused, time-limited groups of approximately 10 to 15 people; (iii) Community dialogues providing support to EVD survivors and other EVD-affected individuals in developing/rebuilding relationships in the community (i.e. working on projects that bring members of the community together to heal, such as local memorials for EVD victims, community gardens, and linking survivors with jobs); (iv) Anti-stigma activities including awareness-raising with a focus on understanding stigma (i.e. what stigma is; how it impacts individuals and communities; and the strengths and contributions of those that are stigmatized); (v) Support-group supervision for community leaders, who will be

encouraged to establish support groups for EVD survivors, first responders, and other individuals directly affected by the virus; (vi) Distribution of self-care tool (to be developed under the project) to selected individuals directly affected by EVD, especially first responders; (vii) Establishment of facility-based referral system to ensure that individuals with serious emotional distress/conditions requiring more care are referred to an appropriate facility; (viii) Capacity-building activities for mental health providers (i.e. MHCs, SWs, gCHVs, PSW/CBRs) and community leaders to ensure that project activities are effectively implemented and to develop the capacity required for sustainable community-based care.

14. The Carter Center, the implementing agency, will implement the interventions under this component. The agency will oversee the different cadres of mental health providers that are carrying out the psychosocial activities (i.e. individual and group counseling, support groups, and community dialogues), and they will work with the CHSWTs to support the implementation of anti-stigma activities. TCC will also contract and work closely with technical experts to adapt and develop capacity-building materials, as well as the self-care tool. All capacity-building activities will be overseen and implemented by TCC.

15. Expected outputs under Component 1 include: (i) Individual counseling provided to 700 individuals directly affected by the EVD crisis; (ii) 3000 individuals participating in group counseling; (iii) Supervision of community leaders running support groups by 17 providers (i.e. MHCs, social workers, of psychosocial counselors/CBR workers); (iv) participation of 180 individuals in community dialogues; (v) 500 individuals that have taken a direct action/made a change as a result of anti-stigma activities; (vi) a new self-care tool for first responders or other individuals directly affected by EVD; (viii) 700 individuals receiving self-care tools; (ix) establishment of referral system to facility-based care for individuals experiencing acute distress or serious mental conditions; (x) referrals to facility-based care (as needed); (xi) adaptation of existing capacity-building materials to the Liberian context and the development of new materials; (xii) 406 mental health providers and community leaders benefiting from capacity-building activities.

Component 2: Support to Build Long-Term Psychosocial Health and Resilience at the Individual and Community Level (US\$1.99 million)

16. Component 2 aims to build resilience and long-term psychosocial health at the individual and community level through the implementation of psychosocial and capacity-building interventions. Existing activities (i.e. individual and group counseling, community dialogues, support groups, and anti-stigma activities) will be strengthened and expanded to a broader population, a significant portion of which has experienced violence and is symptomatic of depression and PTSD. New activities, targeting women, victims of gender-based (GBV), and children, will also be implemented under this component. Taken together, these activities will strengthen Liberia's mental health system, and will effectively build long-term psychosocial health and resilience, thus ensuring that project gains are sustained. Specific activities to be carried out under Component 2 will include: (i) Continuation of individual- and group-level activities implemented under Component 1; (ii) Development of a new cadre of school-based, mental health providers (Child Mental Health Clinicians [CMHCs]) and their deployment at schools across the target counties; (iii) Community-based psychosocial support for children and youth not in school (specific type of support to be determined based on need); (iv) Distribution of women's health toolkit (to be developed under project) and support for women's health; (v) Provision of psychosocial support in health facilities by mid-level cadres; (vi) Capacity building for existing providers (i.e. MHCs, SWs, gCHVs, PSW/CBRs, and mid-level clinicians), religious leaders, and traditional healers on children's mental health, community resilience and recovery,

women's health, and community-based care and outreach; (vii) Capacity building for teachers, school administrators, and other individuals working with children on children's mental health issues.

17. The interventions and associated activities under this component will be implemented and overseen by TCC. The agency will oversee the providers implementing the psychosocial activities, and will be in charge of all capacity-building activities (including the development of the new cadre of CMHCs) and the creation and/or adaptation of associated training materials. TCC will also contract and work with closely technical experts on the development of a women's health toolkit, which will be distributed by a network of existing GBV focal points. Additionally, the implementing agency will work in partnership with the GOL on the placement of CMHCs in schools across the project's target counties.

18. Expected outputs of Component 2 will include: (i) A new cadre of 100 CHMCs; (ii) CHMCs working in 60 schools; (iii) 300 out-of-school children and youth receiving community-based psychosocial support; (iv) A new women's health toolkit; (v) Women receiving the women's health toolkit (number to be determined); (vi) 1500 individuals receiving psychosocial care at the primary level; (vii) continued referrals to facility-based care (as needed); (viii) adaptation of existing capacity-building materials to the Liberian context and the development of new materials; (ix) 389 mental health providers of different cadres (MHCs, SWs, gCHVs, PSW/CBRs, mid-level facility-based clinicians [RM, CM, RN, PA] trained on women's and children's psychical and psychosocial health; (x) 100 religious leaders and 100 traditional healers trained on how identify individuals in acute stress and on the appropriate referral mechanisms; (xi) teachers and other individuals working directly with children trained on how to support children at risk (number to be determined).

Component 3: Project management, monitoring and evaluation (US\$0.25 million)

19. Component 3 provides support to the implementing agency. The implementing agency is responsible for implementing and the day-to-day management of the project's interventions and associated activities; it will also carry out all procurement, financial management, and auditing activities in accordance with Bank procedures. Additionally, the implementing agency will be in charge of project monitoring and evaluation. Specific activities that the implementing agency will carry out include: (i) Developing and implementing an evaluation framework that includes baseline, midline, and endline surveys and a qualitative and participatory component; (ii) Managing, monitoring and documenting project implementation; (iii) Partnering with technical advisors to develop/adapt training materials; (iv) Carrying out the training and capacity building of new and existing cadres of mental health providers; (v) Reviewing lessons learned with project stakeholders and revising implementation plans as necessary; (vi) Holding dissemination workshops with stakeholders to discuss project outcomes and identify next steps.

20. Expected outputs under Component 3 will include: i) Financial management and audit reports; (ii) Biannual learning and review meetings with county-level stakeholders; (iii) Impact evaluation report and summary of qualitative findings; (iv) Report of lessons learned during implementation; (v) One midterm learning and review meeting with representatives from GOL, DPs, and target communities; (vi) One results dissemination workshop at the national-level at end of the project.

IV. Financing

Total Project Cost:	2.75	Total Bank Financing	0.0
Financing Gap:	0.0		
Financing Source			Amount
BORROWER/RECIPIENT			0.0
International Development Association (IDA)			0.0
Japanese Social Development Fun (JSDF)			2.75
Total			2.75

V. Implementation

21. As per the parameters of the Japan Social Development Fund (JSDF) guidelines, neither the World Bank nor the central government can be the project, implementing agency. The team has therefore selected TCC, an NGO, to be the implementing agency.

22. TCC will have direct responsibility and oversight for overall project coordination and management. TCC will be expected to work closely with the MOHSW at the national level, the County Health and Social Welfare Teams (CHSWT) at sub-national levels, and other relevant partners and agencies that may be involved in project intervention areas, in the coordination and implementation of the project. This will help to ensure both technical and institutional sustainability, and alignment and coordination with other relevant agencies. In addition, TCC will also be responsible for organizing technical support; financial oversight of the project; and monitoring and evaluation activities. TCC will be expected to liaise closely with the World Bank in the implementation of project activities. Monthly progress reports, which provide a status update on the operational workplan, will be provided to the Bank on a monthly basis, with weekly updates via email, or audio and videoconferences as needed. Project implementation will span a number of levels: national, county, community. A Project Implementation Manual (PIM) and an Operational Workplan will be developed with the support of local stakeholders.

VI. Safeguard Policies

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01		X
Natural Habitats OP/BP 4.04		X
Forests OP/BP 4.36		X
Pest Management OP 4.09		X
Physical Cultural Resources OP/BP 4.11		X
Indigenous Peoples OP/BP 4.10		X
Involuntary Resettlement OP/BP 4.12		X
Safety of Dams OP/BP 4.37		X
Projects on International Waters OP/BP 7.50		X
Projects in Disputed Areas OP/BP 7.60		X

VII. Contact Point

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ⁱWorld Bank. 2013. Liberia Overview. Available online: <http://www.worldbank.org/en/country/liberia/overview>

ⁱⁱUNDP. 2013. Human Development Report. Available online: <http://www.undp.org/content/dam/undp/library/corporate/HDR/2013GlobalHDR/English/HDR2013%20Report%20English.pdf>

ⁱⁱⁱWorld Bank. 2013. Liberia Overview. Available online: <http://www.worldbank.org/en/country/liberia/overview>

^{iv} World Bank. 2014 The Economic Impact of the 2014 Ebola Epidemic: Short and Medium Term Estimates for Guinea, Liberia, and Sierra Leone. Working Paper 90748.

^vUNICEF. 2011. At a Glance: Liberia. Available online: http://www.unicef.org/infobycountry/liberia_statistics.html

^{vi}WHO. 2013. Country Cooperation Strategy at a Glance. Available online: http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_lbr_en.pdf

^{vii} Johnson K, Asher J, Rosbourough S, et al. 2008. Association of combatant status and sexual violence with health and mental health outcomes in postconflict Liberia. *JAMA*. ;300(6):676-90

^{viii} In addition, neuropsychiatric disorders contribute to an estimated 4.7 percent of the global burden of disease (WHO 2011). The 2010 Global Burden of Disease shows that major depressive disorder contributes to 2.87 percent of the total DALYs in the non-communicable disease (NCD) category among Liberia's working age population. Global Burden of Disease 2010. 2013. Available online: <http://viz.healthmetricsandevaluation.org/gbd-compare/>

^{ix} Luthar, S. et al. 2000. The construct of resilience: A critical evaluation and guidelines for future work. *Child Development*, 71: 543–562.

^x Wu, G. et al. 2013. Understanding resilience. *Frontiers in Behavioral Neuroscience*, 7:1-15.

^{xi} Betancourt, TS and Khan, KT. 2008. The mental health of children affected by armed conflict: protective processes and pathways to resilience. *International Review of Psychiatry*, 20: 317-328.

^{xii} Wener, EE et al. 1982. *Vulnerable but invincible: a longitudinal study of resilient children and youth*. New York: McGraw-Hill. Protective factors refer to external variables whose presence is associated with desirable outcomes in populations at risk for developing poor mental health.

^{xiii} Betancourt, TS and Khan, KT. 2008. The mental health of children affected by armed conflict: protective processes and pathways to resilience. *International Review of Psychiatry*, 20: 317-328.

^{xiv} Wu, G. et al. 2013. Understanding resilience. *Frontiers in Behavioral Neuroscience*, 7:1-15.

^{xv} Wietse, TA et al. 2013 Annual Research Review: Resilience and mental health in children and adolescents living in areas of armed conflict – a systematic review of findings in low- and middle-income countries. *Journal of Child Psychology and Psychiatry* doi:10.1111/jcpp.12053