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Report No: PAD1329

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL GRANT

IN THE AMOUNT OF SDR 1.8 MILLION
(US$2.525 MILLION EQUIVALENT)

AND A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 1.8 MILLION
(US$ 2.475 MILLION EQUIVALENT)

TO THE

REPUBLIC OF THE GAMBIA

FOR A

MATERNAL AND CHILD NUTRITION AND HEALTH RESULTS PROJECT

April 3, 2015

Health, Nutrition and Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective February 28, 2015)

Currency Unit	=	Gambian Dalasi (GMD)
GMD 42.95	=	US$1
US$0.71053510	=	SDR 1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
BFCI	Baby Friendly Community Initiative
CCT	Conditional cash transfer
CPPR	Country Portfolio Performance Review
CRR	Central River Region
EU	European Union
EVD	Ebola Virus Disease
FA	Financing Agreement
GAVI	The Vaccine Alliance
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB and Malaria
GIFMIS	Gambian Integrated Financial Management System
GNI	Gross National Income
HCWMP	Health Care Waste Management Plan
HMIS	Health Management Information System
HRITF	Health Results Innovation Trust Fund
IDA	International Development Association
JPS	Joint Partnership Strategy
LRR	Lower River Region
MCNHRP	Maternal and Child Nutrition and Health Results Project
M&E	Monitoring and evaluation
MOHSW	Ministry of Health and Social Welfare
MOU	Memorandum of Understanding
NaNA	National Nutrition Agency
NBR	North Bank Region
NBR-E	North Bank Region East
NBR-W	North Bank Region West
PAGE	Program for Accelerated Growth and Employment
PBF	Performance-based financing
PDO	Project Development Objective
PHC	Primary Health Care

RAD	Regional Agriculture Directorate
RBF	Results-based financing
RHD	Regional Health Directorate
RHT	Regional Health Team
SBCC	Social and behavior change communication
SDR	Special Drawing Rights
SORT	Systematic Operations Risk-Rating Tool
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
URR	Upper River Region
VDC	Village Development Committee
VSG	Village Support Group
WFP	United Nations World Food Program
WHO	World Health Organization

Vice President:	Makhtar Diop
Country Director:	Vera Songwe
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THE GAMBIA
MATERNAL AND CHILD NUTRITION AND HEALTH RESULTS PROJECT

CONTENTS

Project Paper Data Sheet v

Project Paper

I. Introduction 1

II. Background and Rationale for Additional Financing 2

III. Proposed Changes 8

IV. Appraisal Summary 21

V. World Bank Grievance Redress 27

Annexes

1. Annex 1: Revised Results Framework and Monitoring Indicators 28
2. Annex 2: Detailed Description of Modified and New Project Activities 35
3. Annex 3: Revised Implementation Arrangements and Support 40
4. Annex 4: Systematic Operations Risk-Rating Tool (SORT) 42
5. Annex 5: Map of The Gambia 43

ADDITIONAL FINANCINGDATA SHEET

Gambia, The

GM Maternal and Child Nutrition and Health Results Project (P154007)

AFRICA

GHNDR

Basic Information – Parent			
Parent Project ID:	P143650	Original EA Category:	B - Partial Assessment
Current Closing Date:	31-Jul-2019		

Basic Information – Additional Financing (AF)			
Project ID:	P154007	Additional Financing Type (from AUS):	Scale Up
Regional Vice President:	Makhtar Diop	Proposed EA Category:	
Country Director:	Vera Songwe	Expected Effectiveness Date:	24-Jul-2015
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	31-Jul-2019
Practice Manager/Manager:	Trina S. Haque	Report No:	PAD1329
Team Leader(s):	Rifat Hasan		

Borrower				
Organization Name	Contact	Title	Telephone	Email
The Republic of The Gambia	Abdou Kolley	Minister	220 4227636	abdoukolley@hotmail.com

Project Financing Data–Parent (Maternal and Child Nutrition and Health Results Project-P143650)

Key Dates

Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P143650	IDA-H9230	Effective	21-Mar-2014	09-Apr-2014	20-May-2014	31-Jul-2019	31-Jul-2019
P143650	TF-16640	Effective	09-Apr-2014	09-Apr-2014	20-May-2014	31-Jul-2019	31-Jul-2019

Disbursements

Project	Ln/Cr/TF	Status	Currency	Original	Revised	Cancelled	Disbursed	Undisbursed	% Disburse

									d
P143650	IDA-H9230	Effective	USD	3.68	3.68	0.00	0.24	3.16	6.59
P143650	TF-16640	Effective	USD	5.00	5.00	0.00	0.33	4.67	6.70

Project Financing Data –Additional Financing GM Maternal and Child Nutrition and Health Results Project (P154007)

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

Total Project Cost:	5.00	Total Bank Financing:	5.00
Financing Gap:	0.00		

Financing Source – Additional Financing (AF)	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	5.00
Total	5.00

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	

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Rifat Hasan	Team Leader (ADM Responsible)	Health Specialist	Population and reproductive health, health systems	GHNDR
Mamadou Mansour Mbaye	Procurement Specialist	Consultant		GGODR
Ngor Sene	Financial Management Specialist	Financial Management Specialist		GGODR
Edith Ruguru Mwenda	Counsel	Senior Counsel		LEGAM
Maiada Mahmoud	Team Member	Finance Officer		WFALA

Abdel Fattah Kassem				
Maman-Sani Issa	Environmental Specialist	Senior Environmental Specialist		GENDR
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Sariette Jene M. C. Jippe	Team Member	Program Assistant		GHNDR
Sheila Lucrecia Francisc Pene	Team Member	Senior Finance Assistant		WFALA
Shingira Samantha Masanzu	Team Member	E T Consultant		LEGAM

Extended Team

Name	Title	Location

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
		Upper River Division		X	
Gambia, The		Upper River Division			
		North Bank Division		X	
Gambia, The		North Bank Division			
		Central River Division		X	
Gambia, The		Central River Division			
Gambia, The	Lower River	Lower River Division	X		

Institutional Data

Parent (Maternal and Child Nutrition and Health Results Project-P143650)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change

[ ] Fragile, Conflict & Violence

[ ] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	86		
Public Administration, Law, and Justice	General public administration sector	14		
Total		100		

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Nutrition and food security	35
Human development	Health system performance	25
Human development	Child health	20
Human development	Population and reproductive health	20
Total		100

Additional Financing GM Maternal and Child Nutrition and Health Results Project (P154007)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Cross Cutting Topics

[ ] Climate Change

[ ] Fragile, Conflict & Violence

[X] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	50		
Health and other social services	Other social services	50		
Total		100		

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Nutrition and food security	40
Human development	Population and reproductive health	20
Human development	Health system performance	20
Human development	Child health	20
Total		100

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required? Consultants will be required

I. Introduction

1. This Project Paper seeks the approval of the Executive Directors to provide an Additional Financing Grant in an amount of SDR 1.80 million (US$2.525 million equivalent) and Credit in an amount of SDR 1.80 million (US$2.475 million equivalent) to the Republic of The Gambia Maternal and Child Nutrition and Health Results Project (MCNHRP; P143650; H9230-GM). The MCNHRP is an SDR 2.4 million (US$3.68 million equivalent) IDA Grant (H9230-GM) co-financed by a US$5.0 million Grant from the Multi-Donor Trust Fund for Health Results Innovation (HRITF) (TF016640-GM) both of which were approved on March 21, 2014. The closing date of the original project is July 31, 2019. The MCNHRP was restructured on December 1, 2014 to include a new component on Ebola Virus Disease Preparedness and Control. As of March 3, 2015, seven percent of the IDA and Trust Fund proceeds have been disbursed.

2. The proposed Additional Financing (AF) would help finance the costs associated with new activities included as part of project restructuring in response to a looming food and nutrition security crisis resulting from poor and erratic rainfall in 2014, reallocation and additional support for Ebola response activities, and the expansion of original project activities to enhance the impact of the existing project. The AF is necessary because the original project's resources are locked into a results-based financing (RBF) approach for health, which impedes effective and rapid response to the food and nutrition security crisis. The currently low level of disbursement is expected because the RBF funds can only be disbursed after initial preparatory activities are completed, RBF contracts signed, and performance on agreed indicators verified. Disbursement is expected to pick up shortly now that contracts are signed and Ebola preparedness activities are ready to start disbursing. By the time the AF is approved, 23% of the IDA and 9% of the HRITF are expected to be disbursed.

3. The overall objective of the project is to improve health and nutrition outcomes among women and children while focusing on the least served Regions. The new food security activities fit adequately under the conceptual framework that links nutrition with food security, caring practices, health environment and health services: food security is one of the main determinants of malnutrition and can be addressed at the community level. Therefore, the Project Development Objective (PDO) of the MCNHRP remains unchanged and is to increase the utilization of community nutrition and primary maternal and child health services in selected regions in the Recipient's territory. One new PDO outcome indicator and two new intermediate outcome indicators have been added to reflect the additional activities aimed at enhancing household food and nutrition security.

4. The proposed changes will strengthen the Project's long term objectives of reducing maternal and child mortality and undernutrition, thereby contributing to the attainment of MDGs 1c, 4 and 5 and the Health, Nutrition and Population Global Practice goal of ending preventable deaths and disability through Universal Health Coverage. The relationship between nutrition, health, and wealth is well-established, with better health and nutrition resulting in enhanced cognitive development, increased human capital and a more productive labor force who are economically better off with intergenerational dividends. Furthermore, this project will be implemented in the worst performing regions in The Gambia in terms of health and nutrition outcomes – improving nutrition, health and development outcomes in these particular regions

will bridge the gap with those better off. Thus, the project will contribute to the Bank's twin goals of eliminating extreme poverty and boosting shared prosperity.

5. The AF will specifically:

a. Include issues of food security in the Social and Behavior Change Communication (SBCC) Strategy and food security indicators in the community RBF contracts under Component 1;
b. Introduce household food and nutrition security interventions in the Baby Friendly Community Initiative (BFCI) strategy in the current Project Regions (North Bank West, Upper River and Central River Regions), and scale up the food security-enhanced BFCI and Primary Health Care (PHC) additionally to North Bank East and Lower River Regions under Component 2 (map in Annex 5);
c. Expand RBF for community nutrition and health service delivery to the North Bank East and Lower River Regions under Component 2;
d. Replenish funds allocated to Ebola Preparedness and Control under the restructuring of December 2014; and
e. Increase scale and intensity of ongoing capacity building for service delivery and RBF due to the geographic expansion and expansion of scope of activities under Component 3.

6. The MCNHRP is instrumental in accelerating a reform process initiated by UNICEF to revitalize primary health care. A technical working group of development partners (e.g., UNICEF, UNFPA, WHO, GFATM, GAVI and the European Union) and the Project Implementation Committee (PIC) composed of the Ministry of Health and Social Welfare (MOHSW) and the National Nutrition Agency (NaNA) has been formed to coordinate efforts in the health sector. The Project also coordinates with the EU and WFP on efforts related to safety net programs including cash transfers (EU) and feeding programs as well as school gardens (WFP). Lastly, the Project coordinates with the agricultural sector on programs related to small scale food production and women's empowerment. The EU and WFP are the main partners for the food security aspect of the project with the others (UNICEF, UNFPA, GFATM and GAVI) more involved in the health and other nutrition aspects of the project. Specifically on Ebola, a National Task Force for Ebola Response, chaired by the Minister of Health and Social Welfare, has been established and includes a range of partners for both technical and financing roles (e.g. WHO, UNICEF, UNDP).

II. Background and Rationale for Additional Financing in the amount of $5.0 million

A. Background

7. The MCNHRP (P143650) has two sources of financing: (i) an International Development Association (IDA) Grant of SDR2.4 million (US$3.68 million equivalent) and (ii) a US$5.0 million grant from the Multi-Donor Trust Fund of Health Results Innovation (HRITF; TF016640) which were approved by the Executive Directors and Regional Vice President, respectively, on March 21, 2014 and became effective on May 20, 2014 with a closing date of

July 31, 2019. To date, approximately seven percent of each grant has been disbursed, though disbursements are expected to rapidly increase over the next few month following the signing of RBF contracts with health facilities and communities.

8. The project's development (PDO) objective is to increase the utilization of community nutrition and primary maternal and child health services in selected regions in the Recipient's territory. The PDO remains unchanged on the understanding that nutrition services include the aspects of food, health and care as per the internationally accepted conceptual framework for nutrition. The original project included three components, i.e.: (i) community mobilization for social and behavior change; (ii) delivery of selected primary health care services; and (iii) capacity building for service delivery and results based financing. The MCNHRP was restructured on December 1, 2014 to reallocate SDR330,000 (US$500,000 equivalent) to create a fourth component to support the government in its immediate efforts on Ebola: (iv) Ebola prevention and control.

9. The Gambia has been affected by the threat of two potential emergencies. As indicated by the restructuring, the Ebola epidemic could surface in The Gambia at any time, which, given the weak capacity of the health system to respond effectively, is a major concern. In addition, the 2014 rains arrived late and were erratic. Agriculture, the main source of livelihood for two thirds of the population, is heavily dependent on rain. As a result, current estimates predict that the harvest will contract by 15% compared to last year's harvest, and a dramatic increase in food and nutrition insecurity is to be expected in the coming months.

10. The Bank received a request for AF for the MCNHRP from the Government of The Gambia on December 16, 2014. The AF would consolidate early achievements and support the response to the dual emergencies threatening the PDO by enhancing food and nutrition security activities, scaling up community nutrition and primary health care services, strengthening the Ebola response, and replenishing the initial reallocation of funds for Ebola. Thus, the AF would support both a scale-up of activities to enhance development impact and a modification of project activities to quickly address the looming food and nutrition security crisis. The integrated approach of enhancing household food security, community nutrition and primary health care will strengthen the resilience of communities and households to food and nutrition insecurity shocks.

11. The request is consistent with the Bank's guidelines for AF, namely: (i) the Project is rated satisfactory on both PDO and Implementation Progress; (ii) all legal covenants have been complied with and there are no outstanding audit reports; and (iii) the Project will follow the World Bank's "Guidelines for the Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" both dated July 2011 and revised July 2014.

B. Country and Sectoral Context

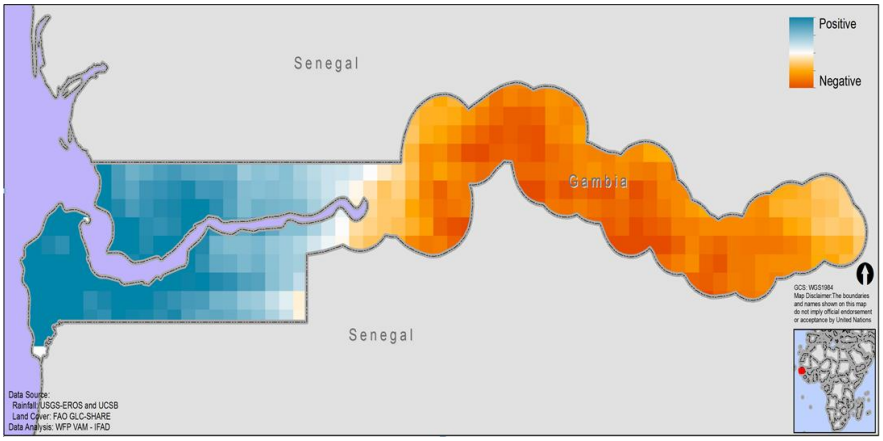
12. The Gambia is a small country in West Africa with a population of approximately 1.8 million (2012). The population has been growing at a fairly high rate of 3.3 percent per year over the last decade. The Gambia is a low income country with average per capita Gross National

Income (GNI) estimated at US$610 (2011) which is half of the sub-Saharan African average of US$1,255. The 2011 Human Development Index shows the country at rank 168 out of 187 countries. Life expectancy at birth for the average Gambian is 58 years.

13. Poverty in The Gambia is pervasive in spite of a noticeable decline of overall poverty rates during the last decade. The overall poverty head count index is estimated at 48.4 percent (upper poverty line: US$1.25 a day), down from an estimated 58.0 percent. Given a relatively undiversified economy, the country remains highly vulnerable to external shocks, with heavy dependence on rain-fed crops for agricultural production, imports for food security, and tourism receipts and remittances for foreign exchange earnings. Real GDP growth is estimated to have contracted by 0.2 percent in 2014, following 4.8 percent growth in 2013, tied to shocks in the tourism and agricultural sectors, and the drag of cumulative policy mismanagement. Although there have been no reported cases of Ebola in The Gambia, the sub-regional outbreak has led to an estimated 60 percent decline in tourist arrivals for the 2014/2015 tourist season. Agricultural production is estimated to have contracted by 15 percent, including a fall-off in cereal and pasture production, for the 2014/2015 crop year. Policy mismanagement over recent years—including pronounced fiscal slippage, ad hoc monetary policy shifts and central bank financing of the deficit—has contributed to heightened uncertainty, reflected in high borrowing rates that persisted in 2014.

14. **Food and Nutrition Security:** Food and nutrition security is premised on sufficient quantities of food being available consistently, sufficient access to appropriate foods for a nutritious diet, and appropriate use based on knowledge of basic nutrition and care. In The Gambia, this is a challenge. The country is heavily dependent on rain for agricultural output and on imports for food consumption. This leaves the country highly vulnerable to the changing climate conditions, notably decreasing and erratic rainfall and shorter cropping cycles. Two thirds of the population depends on agriculture for their livelihood, yet a significant proportion of cereal, mainly rice, on the market is imported (up to 50%). With this year's rains being late and insufficient, crop sowing started late and overall crop production is estimated to contract by 15%. The most affected crops include rice (upland), maize, early millet, and groundnut. Households will run out of cereal supply earlier than normal and not have the financial means from groundnut trade to afford the imports. As a result, food and nutrition insecurity is expected to rise earlier and faster than normal and women and children are particularly vulnerable. The Regions that suffered the greatest deficits in rainfall (Figure 1) include the North Bank Region (NBR) East, Upper River Region (URR), Central River Region (CRR) North and South , and Lower River Region (LRR).

Figure 1: Rainfall trends in The Gambia, April-October (against last 20 years)



Source: www.usgs.com

15. In 2013, a household survey by the World Food Programme (WFP) concluded that rural households are more affected (21%) by food insecurity than urban households (6%), and food insecurity is most severe in CRR South (27%), LRR (24%), West Coast Region (WCR; 23%) and NBR (21%). The most recent survey on acute malnutrition (i.e., wasting) also dates from 2013. The Regions with wasting rates of 10 percent or higher (i.e., WHO cut-off for crisis situation) include URR (17%), CRR North (16%), CRR South (11%), LRR (11%), Kanifing Area in the Banjul Region (11%), and NBR (10%).

16. Using data on current rainfall deficit, recent rice price increases from January 2014 to August 2014, 2013 food insecurity and the 2013 prevalence of wasting, a risk "score" was constructed for the looming food crisis in early 2015 by Local Government Area (LGA) (Table 1). The high-risk LGAs include LRR, NBR, CRR, and URR, which are home to approximately 770,000 people (i.e., approximately 91,000 households) or 41 percent of the total population. In these Regions, the lean season is expected to start as early as March 2015.

Table 1: Risk factors for food and nutrition insecurity in early 2015 by LGA

LGA	Rainfall deficit 2014[1]	Rice price rise 2014[2]	Food in-security 2013	Wasting 2013	Risk Score[3]
Banjul	-	9	0	9	0
Kanifing	-	3	0	11	1
Brikama (WCR)	-	2	23	9	1
Mansakonko (LRR)	+	12	24	11	**4**
Kerewan (NBR)	+	22	21	10	**4**
Kuntaur (CRR-N)	+	18	13	16	**3**
Jajanbureh (CRR-S)	+	17	27	11	**4**
Basse (URR)	+	38	7	17	**3**

1 Based on rainfall data on Senegal (*www.fews.net*)
2 Price increase (%) for local rice from January to August 2014
3 Rainfall deficit; Rice price increase of 10% or more; Food insecurity of 20% or more; wasting of 10% or more

17. **Food Security and Health and Nutrition Outcomes:** Food security is a complex issue linked most directly to health through malnutrition. Malnutrition directly weakens the individual's immune system, making him/her more vulnerable to infectious diseases such as diarrhea, acute respiratory infections and malaria. Malnutrition has also persistently been associated with increased severity of infectious diseases. In addition, malnutrition in early childhood irreversibly impairs proper development of the immune system as well as other functions (e.g., cognitive and physical functions).

18. The problem of undernutrition in The Gambia is profound and pervasive. Of children under age 5, 16 percent are underweight (thin for their age), 12 percent are wasted (thin for their height), and 25 percent are stunted (short for their age) (DHS 2013). The percentage of children who are underweight has remained stagnant since 2000. Stunting and wasting have actually worsened since 2010. Therefore, undernutrition is a major cause of lost intellectual potential in the Gambian population. This is mainly through direct losses in productivity linked to poor physical status; and indirect losses due to poor cognitive function and learning deficits, as well as losses resulting from increased medical costs. The need to intervene in nutrition and food security multisectorally (i.e. by addressing both direct and indirect determinants of malnutrition) and during the critical window of opportunity (between conception and the first two years of a child's life) is central to this project and contributes to not only food and nutrition security specifically but also health and nutrition outcomes more broadly. Malnutrition is a contributing cause of almost half of under-five mortality[1], which is still high in The Gambia at 54 deaths per 1,000 live births. Child mortality is also higher in rural areas than in urban areas.

19. Maternal mortality is 360 per 100,000 live births and unlikely to reach the MDG 5 target. According to the 2013 State of the World's Mothers (Save the Children 2013), The Gambia ranks 170 out of 176 countries on the Mother's Index just ahead of Mali, Niger and Central African Republic but behind countries like Chad, Guinea-Bissau and Nigeria.[2] Total fertility rate (TFR) has actually increased to 5.6 children per woman while contraceptive prevalence rate (CPR) has dropped to 9 percent. Unmet need for family planning is estimated at 22 percent. The percentage of women who had skilled attendance at delivery – 57 percent – has remained unchanged since 2000. At least one antenatal care (ANC) visit by a skilled provider, nearly universal in 2005/06, has dropped to 86 percent (2013) and does not vary by level of education. The 2011 Maternal and Perinatal Audit of Royal Victoria Teaching Hospital highlighted delayed access to referral services by pregnant women as a major contributing factor to high maternal mortality. Furthermore, teenage pregnancies are common, resulting in a high adolescent fertility rate of 88 per 1,000 (DHS 2013). Of adolescent girls age 15-19, 18 percent have begun childbearing – this figure increases to 24 percent in rural areas. Pregnancy in adolescence raises the risk for maternal mortality, morbidity and child malnutrition. Utilization of health services by youth is low, and few facilities offer youth-friendly reproductive health services.

[1] Black et. Al. (2013). Maternal and child undernutrition and overweight in low-income and middle-income countries. The Lancet, Volume 382, Issue 9890, Pages 427-51.

[2] Indicators of the 2013 Mother's Index include: (i) Lifetime risk of maternal death; (ii) Under-5 mortality rate; (iii) Expected years of formal education; (iv) Gross national income per capita; and (iv) Participation of women in national government

20. **Ebola:** The 2014 Ebola epidemic is the worst in history, affecting multiple countries in West Africa with Liberia, Sierra Leone and Guinea most affected and cases having emerged in Senegal, Mali and Nigeria. The health sectors in the most affected countries have been systematically devastated, and the provision of primary maternal and child health care services has suffered, setting back recent progress that has been made on health sector outcomes in these countries. Although there are no confirmed cases of Ebola in The Gambia to date, given its proximity to the affected countries, the country is at high risk for an Ebola outbreak. The greatest concern at this stage is the weak operational capacity to prevent and control the transmission of Ebola through sound, simple, preventive, and mitigating public health actions.

21. A National Task Force for Ebola Response, chaired by the Minister of Health and Social Welfare, has been established. An Ebola Emergency Preparedness and Response Plan was developed in collaboration with WHO, UNICEF and other development partners, and nationally validated in November 2014. The plan is costed at US$4.68 million.

C. Opportunities from Successful Implementation

22. With a separate grant of US$850,000 from the HRITF, a pilot was started in NBR West in December 2013 to test out the new RBF mechanisms and apply lessons learned to the main project. Promising results have emerged from the one year of pilot implementation, including a dramatic improvement in quality of care. For example, between 2013 and 2014, the proportion of health facility deliveries attended by a midwife increased from 55% to 82% and from 82% to 88% in two pilot areas. Quality of care is perceived to have improved among community members in the pilot catchment areas, which can be a motivating factor for seeking care. Similarly, antenatal care coverage has increased substantially in the intervention areas. Staff motivation, job satisfaction and innovation appear to have improved in pilot health facilities, and at the community level, there is evidence of increased demand for knowledge with women wanting to be better informed for decision-making around health and nutrition. Furthermore, some communities have mobilized to use RBF payments to help women – for example, one community has been saving multiple rounds of RBF payments to purchase a donkey cart to transport women to health facilities for delivery. These promising results point to an opportunity to: (i) expand the approach beyond the current expansion to CRR and URR to include other priority Regions including NBR East and LRR; and (ii) build on the experience of working with Village Support Groups (VSG) and Village Development Committees (VDC) to broaden the scope of community action for improved health and nutrition outcomes by including household food security concerns.

D. Higher Level Objectives to which the Project Contributes

23. The overall objective of the project is to improve health and nutrition outcomes among women and children by focusing on the least served Regions. The proposed changes will support the long term objectives of reducing maternal and child mortality and undernutrition and thereby contribute to the attainment of MDGs 1c, 4 and 5. Thus, the AF will contribute to the Health, Nutrition and Population Global Practice goal of ending preventable deaths and disability

through Universal Health Coverage. Improved health and nutrition improves human capital and produces more productive individuals who are better off economically. In addition, this project will be implemented in the worst performing regions in The Gambia – improving their nutrition, health and development outcomes will bridge the gap with those better off, thereby, contributing to the Bank's twin goals of eliminating extreme poverty and boosting shared prosperity.

24. The proposed changes are fully aligned with the priorities of the Government which are to reinforce gains in welfare over the past five years in addition to sustaining recent economic achievements by accelerating growth and employment as laid out in the Program for Accelerated Growth and Employment (PAGE; 2012-2015). Improving human capital and social services, in particular access to and quality of health services and nutrition and food security interventions, are among the strategic priorities for poverty reduction. These priorities are also reflected in the Joint Partnership Strategy (JPS) which explicitly makes the case to support the government in achieving improved outcomes in maternal and child health and nutrition. The MCNHRP contributions to these priorities were re-affirmed during the Mid-Term Review of the JPS in December 2014.

25. The project complements other Bank-supported investment projects, notably those in agriculture (i.e., the West Africa Agriculture Productivity Program and the Commercial Agriculture and Value Chain Management Project), that impact on health and nutrition outcomes. The AF will create synergies between these different Bank-supported investment projects in health, nutrition, food security and agriculture.

III. Proposed Changes

Summary of Proposed Changes

The proposed AF would help finance the costs associated with scaled-up activities to enhance the impact of the project and new activities included as part of project restructuring in response to a looming food and nutrition security crisis as a result of poor and erratic rainfall in 2014. The Additional Financing will:

a. Include issues of food security in the Social and Behavior Change Communication (SBCC) Strategy and food security indicators in the community RBF contracts under Component 1;

b. Introduce household food and nutrition security interventions in the Baby Friendly Community Initiative (BFCI) strategy in the current Project Regions (North Bank West, Upper River and Central River Regions), and scale up the food security-enhanced BFCI and Primary Health Care (PHC) additionally to North Bank East and Lower River Regions under Component 2;

c. Expand performance-based financing (PBF) for health and nutrition service delivery to the North Bank East and Lower River Regions under Component 2;

d. Replenish the funds allocated to Ebola preparedness and control under the restructuring of December 2014; and

e. Increase scale and intensity of ongoing capacity building for service delivery and RBF due to the geographic expansion and expansion of scope of activities under Component 3.

The Project Development Objective (PDO) of the MCNHRP remains unchanged and is to increase the utilization of community nutrition and primary maternal and child health services in selected regions in the Recipient's territory. One outcome indicator, being the same as an intermediate-level Core indicator, has been deleted. One new PDO outcome indicator and three new intermediate outcome indicators have been added to reflect the additional activities aimed at enhancing household food and nutrition security.

The current project is being implemented in three regions, accounting for one third of the total population with an expectation of reaching approximately 183,000 children under five and 180,000 women aged 15-49 years, yielding a total of 363,000 direct beneficiaries. The proposed AF will reach these individuals with the additional food security interventions. In addition, the AF will reach an additional 114,000 new direct beneficiaries (52,700 children under five and 61,800 women aged 15-49 years) in the two new regions with the full package of interventions.

Change in Implementing Agency	Yes [ ] No [X]
Change in Project's Development Objectives	Yes [ ] No [X]
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 [ ] No [X]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [ ] No [X]
Reallocation between Disbursement Categories	Yes [ ] No [X]
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 [X] No [ ]
Change in Procurement	Yes [X] No [ ]
Change in Implementation Schedule	Yes [ ] No [X]
Other Change(s)	Yes [ ] No [X]

Development Objective/Results

Project's Development Objectives

Original PDO

A. Proposed Development Objective

The development objective of the project is to increase the utilization of community nutrition and primary maternal and child health services in selected regions in the Recipient's territory.

Change in Results Framework

Explanation:

The PDO remains unchanged.

One PDO indicator, which was a duplicate of an intermediate-level Core indicator, has been deleted, and one new PDO outcome indicator has been added to reflect the additional activities aimed at enhancing household food and nutrition security:
Deleted: Children between the age of 6 and 59 months receiving Vitamin A supplementation (number)
New: Children 6-23 months consuming at least four out of six food groups (%)

In addition, three new intermediate outcome indicators have been added to monitor results related to food and nutrition security:
New: Vulnerable households supported in participating in gardening or keeping ruminants or poultry (number)
New: Communities supported in establishing child food banks (number).
New: BFCI villages in the selected regions (number)

Targets of the original indicators have also been adjusted to reflect the scaling up of activities to two additional regions. The amended Results Framework is shown in Annex 1.

Compliance

Covenants - Additional Financing (GM Maternal and Child Nutrition and Health Results Project - P154007)

Source of Funds	Finance Agreement Reference	Description of Covenants	Date Due	Recurrent	Frequency	Action
				☐		

Covenants - Parent (Maternal and Child Nutrition and Health Results Project - P143650)

The Country Portfolio Performance Review (CPPR) on May 2, 2013 decided that all new Projects must use the Gambian Integrated Financial Management System (GIFMIS). However, the Recipient has informed the Bank that, technically, they are unable to roll out the GIFMIS to NaNA by fifteen (15) months after effectiveness as previously announced. An estimate of when GIFMIS technical issues will be resolved and GIFMIS rolled out to NaNA is uncertain. Therefore, the dated covenant in the original FA on the use of GIFMIS as the Project's financial information system within fifteen (15) months after Effective Date is annulled. The project will continue this high level of performance and will eventually use GIFMIS when it is technically sound and becomes available but will not be bound by a dated covenant. Deleting this covenant will not have a negative impact on the project or result in a gap in fiduciary arrangements as the project has been under implementation since May 2014 with satisfactory progress towards achievement of PDO, overall implementation progress, and specifically on financial management.

Ln/Cr/TF	Finance Agreement Reference	Description of Covenants	Date Due	Status	Recurrent	Frequency	Action
IDA-H9230		Finance Agreement: Recruitment of External Auditor | Description: The Recipient shall recruit, not later than six (6) months after the Effective Date, the external auditor referred to in Section 4.09 (b) of the General Conditions in accordance with Section III of Schedule 2 of the Financing Agreement and pursuant to terms of reference satisfactory to the Association, to carry out such functions as set forth in the Project Operations Manual. | Due Date: 30-Jan-2015		Complied with	☐		No Change

IDA-H9230		Finance Agreement: Roll-out of GIFMIS | Description: The Recipient shall, not later than fifteen (15) months after the Effective Date, adopt, and thereafter use at all times during the implementation of the Project, the Gambian Integrated Financial Management Information System (GIFMIS) as the Project's financial information system. | Due Date: 30-Sep-2015		Not yet due	☐		Marked for Deletion
IDA-H9230		Finance Agreement: Recruitment of IVA | Description: The Recipient shall, not later than six months (6) months after the Effective Date, recruit an Independent Verification Agent (IVA) in accordance with the provisions of Section III of Schedule 2 to this Agreement, and with qualifications, experience and terms of reference acceptable to the Association. | Due Date: 30-Jan-2015		Complied with	☐		No Change

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

Finance

Loan Closing Date - Additional Financing (GM Maternal and Child Nutrition and Health Results Project - P154007)

Source of Funds	Proposed Additional Financing Loan Closing Date
International Development Association (IDA)	31-Jul-2019

Change in Disbursement Estimates **(including all sources of Financing)**

Explanation:

Additional financing of US$5 million are expected to be disbursed as follows.

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

Fiscal Year	2015	2016	2017	2018	2019	2020
Annual	0.00	0.40	0.80	1.90	1.30	0.60
Cumulative	0.00	0.40	1.20	3.10	4.40	5.00

Allocations - Additional Financing (GM Maternal and Child Nutrition and Health Results Project - P154007)

Source of Fund	Currency	Category of Expenditure	Allocation	Disbursement %(Type Total)
			Proposed	Proposed
IDA	XDR	(1)(a) Conditional Cash Transfers under Parts A.1 and A.2 of the Project in NBR-W,	0.00	0.00

		CRR, and URR		
IDA	XDR	(1)(b) Conditional Cash Transfers under Parts A.1 and A.2 of the Project in NBR-E and LRR	0.85	23.61
IDA	XDR	2(a) PBF Grants under Part B.1 of the Project in NBR-W, CRR, and URR	0.00	0.00
IDA	XDR	2(b) PBF Grants under Part B.1 of the Project in NBR-E and LRR	0.60	16.67
IDA	XDR	(3)(a) GDS,WK,NCS,CS,TRG OP under Part B.2, of the Project in NBR-W, CRR, and URR	0.00	0.00
IDA	XDR	(3)(b) GDS,WK,NCS,CS,TRG OP under Part B.2, of the Project in NBR-E and LRR	0.43	11.94
IDA	XDR	(4) GDS,WK,NCS,CS,TRG OP under Parts A.3 and C of the Project	1.54	42.78
IDA	XDR	(5) GDS,WK,NCS,CS,TRG OP under Part B.3 of the Project	0.18	5.00
		Total:	3.60	

Components

Change to Components and Cost

Explanation:

The AF will support new food and nutrition security activities, the replenishment of the reallocation and additional support for Ebola response activities, and the expansion of original project activities in the MCNHRP (P143650). The MCNHRP is currently being scaled up in the western half of North Bank

Region (NBR-W), the Central River Region (CRR) and Upper River Region (URR). The AF would support new areas in the eastern half of North Bank Region (NBR-E) and Lower River Region (LRR) which have a total population of approximately 200,000 to be added to the MCNHRP.

Component 1: Community Mobilization for Social and Behavior Change
- Conditional cash transfers to communities and support groups
- Conditional cash transfer to individuals
- Social and behavior change communication (SBCC)

Component 2: Delivery of Community Nutrition and Primary Health Care Services
- Performance-based financing (PBF) for health facilities
- Start-up support, including selected health care waste management measures
- Health system strengthening for Ebola preparedness and control
- PHC scale-up
- Food security-enhanced BFCI scale-up

Component 3: Capacity Building for Service Delivery and RBF
- Capacity building
- M&E, operational research and verification
- Coordination and program management at all levels
- Performance contracts with RHD, RAD, RBF Committee, and NaNA

Component 4: Ebola Preparedness and Control
- Social mobilization
- Case management

COMPONENT 1 – Community Mobilization for Social and Behavior Change (Total US$4.15 million, including: US$1.80 million AF; US$0.91 million IDA; US$1.44 million HRITF): This component currently supports: (i) RBF contracts (through conditional cash transfers, CCTs) with communities and VSGs to increase demand for and utilization of health and nutrition services through counseling and timely referrals for life-saving health services (e.g., hygiene, sanitation, counseling on infant and young child feeding, delayed first pregnancy and child spacing, referral of pregnant women and children with danger signs to health centers); (ii) CCTs to individual women to increase utilization of timely antenatal care; and (iii) accompanying measures aimed at promoting behavior changes and increasing demand to improve household practices related to health and nutrition through social and behavior change communication (SBCC; which includes technical advisory services and training).

The proposed change to this component is to expand the scope of the community agreements and the accompanying measures to include food security indicators and messages. The additional indicators and messages will relate to the expanded service delivery activities described under Component 2 and cover off-season and diversified food production of vegetables, fruits, ruminants and poultry by vulnerable households, use of improved vegetable seed and ruminant/poultry race varieties, use of improved (staple) food storage facilities, adoption of appropriate food transformation technologies, the establishment of child food banks at community level, diversified food intake, the commercialization of excess production, and increased plot allocation for small-scale food production to women in vulnerable households. The community RBF contracts will be gradually expanded to the two additional Regions, NBR-E and LRR, similarly to the expansion in the original Regions by adding batches of a manageable number of community contracts. The accompanying measures which refer to comprehensive SBCC strategies will be scaled up to all communities of the five Project Regions independent of the community RBF contracts.

COMPONENT 2 – Delivery of Community Nutrition and PHC Services (Total US$5.83 million, including: US$2.30 million AF; US$1.35 million IDA; US$2.18 HRITF): This Component currently supports the delivery of nutrition and primary health care services through (i) PBF grants to health centers for the delivery of a predefined package of maternal and child health and nutrition services at primary and referral health care facilities; and (ii) startup support for effective service delivery, including the implementation of selected health care waste management measures. This package is being implemented in NBR-W, CRR and URR. The proposed changes to this component are:

(a) PBF package (as described above) expansion to NBR-E and LRR;
(b) Ebola preparedness and control;
(c) PHC scale-up extended to NBR-E and LRR in support of the MOHSW strategy; and
(d) Food security-enhanced BFCI scale-up across the five regions.

PBF Package Expansion: The above package is being implemented in 24 health facilities in NBR-W, CRR and URR, and the additional financing will expand this to include another 13 facilities across NBR-E and LRR. Health facilities sign a PBF contract with the MOHSW RBF Committee and receive quarterly payments corresponding to their achieved performance. A fee-for-service mechanism, including quantity and quality payments, is being employed with payments triggered following quantity verification by NaNA. The final amount is determined following quality verification by Regional Health Directorates (RHDs). (The RHDs were formerly known as Regional Health Teams, RHTs, until recently. In the original project document, RHDs are referred to as RHTs.) Health facilities can use their payments for material and equipment, training, consulting services and operating costs, and staff bonuses that will ultimately improve service delivery. Facilities have sufficient decision space for social entrepreneurship to use the performance payments to improve the demand and quality of services provided. As part of the PBF contracting cycle, each health facility develops a business plan which serves as a guide for future investments and use of payments.

Ebola Preparedness and Control: The AF will provide US$0.25 million to support health system strengthening efforts to improve Ebola preparedness and control under Component 4. Activities will address strengthening the data management system (e.g. review of and training on Integrated Disease Surveillance and Response, procurement of data cards to expand reliable internet access at regional level and health facilities) and improving the reporting system (e.g. training of health care workers on reporting, monitoring and supervision). The AF is focusing on broader health system strengthening that is relevant to not only Ebola but other infectious diseases as well.

Given the evolving nature of the epidemic risk, the Ebola Response Plan is likely to adapt over the course of the project. Thus, the AF will maintain a degree of flexibility around specific activities to be financed and will support the evolving needs in consultation with the National Ebola Task Force, which coordinates all Ebola activities and is comprised of the government and partners. The project will coordinate closely with the Task Force to ensure that changes in planning are taken into account for implementation of activities. With the restructuring and AF combined, the Bank will support US$0.75 million toward the implementation of the National Ebola Response Plan, which will help the health system not only prepare for a potential epidemic but also mitigate risks to delivery of maternal and child health and nutrition services, thereby contributing to the PDO. Other donors are also contributing to the implementation of the Ebola Response Plan (e.g. UNDP, UNICEF, and WHO).

PHC Scale-Up: The government's Primary Health Care (PHC) Strategy indicates services are to be delivered through three levels of care: (i) the primary level consisting of a network of village health posts of community health workers, (ii) the secondary level consisting of a network of minor and major health centers, and (iii) the tertiary level providing more specialized services and functioning as a referral service for the secondary level. However, financing has increasingly prioritized the tertiary level, resulting in an

operationally weakened and under-funded PHC system and inadequate linkages between communities and the health sector. The government has adopted a policy to revitalize PHC, and the current project is supporting this already. The AF in Component 2 will support the PHC scale-up to NBR-E and LRR to strengthen community-level structures and the linkages to health facilities according to agreed-upon criteria for scale-up. Given the early onset of the hungry season, particular focus will be put on the treatment response to active case finding for acute malnutrition. The current coverage of the treatment of severe and moderate acute malnutrition is low and needs to be strengthened through active screening. The PHC scale-up will also facilitate the community-RBF expansion.

Food security-enhanced BFCI Scale-Up: The Baby Friendly Community Initiative (BFCI) scale-up is supported in the current project. The AF expands the current BFCI scale-up in terms of both scope and scale. In terms of scope, the AF will support an enhanced version of the BFCI to strengthen local food and nutrition security by building on the experiences of the previous Rapid Response Nutrition Security Improvement Project and the current MCNHRP. Activities that will be added to the BFCI will collectively address both the *immediate household food crisis and medium-term resilience*. Activities aimed at the *immediate response* include: (i) active screening for early signs of malnutrition and provision of treatment at community level for cases of moderate acute malnutrition and through inpatient and outpatient basis at health centers for severe acute malnutrition with or without complications respectively; (ii) the targeted promotion and enhancement of off-season diversified household and community food production through backyard and community gardens; (iii) small livestock husbandry; and (iv) use of improved seed varieties and animal races. Activities aimed at *building resilience* at the household and community levels include: (i) promotion and use of appropriate food production; (ii) storage and transformation technologies; and (iii) planting of fruit trees and establishment of child-focused community food banks for use during nutritional emergencies. With the recognition that community needs vary, a community diagnostic will be applied to determine feasibility of specific interventions in each community.

The most affected regions for food and nutrition insecurity are LRR, NBR, CRR and URR (inhabited by approximately 770,000 people in 91,000 households, or 46 percent of the total population). The most vulnerable people to food and nutrition insecurity shocks are women and children. According to the 2014 gender assessment by the World Bank, women generally have limited control over resources but play essential roles in the production of food, the consumption in the household and the reproduction of the family. Therefore, the immediate beneficiaries of the food security-enhanced BFCI scale-up will be women and children in food and nutrition insecure households and communities. The food-security enhanced BFCI scale up will use community organization structures to identify eligible beneficiaries (pregnant women and mothers of young children in vulnerable families), who will receive support for the small-scale food security interventions (identification of vulnerable households described in greater detail in Annex 2).

Activities in Components 1 and 2 (specifically SBCC and PHC and BFCI scale up) are aimed primarily at bridging the critical gap between communities and the services they need. The SBCC Strategy in Component 1 will identify the various barriers, specific target audiences (e.g. women, men, adolescents, religious leaders, etc.), key tailored messages, and appropriate delivery mechanism of the messages to improve demand for and uptake of services. The BFCI scale-up in Component 2 will scale-up the structures required to enable communities to be baby friendly – i.e. establishing and training VSGs. The BFCI will be one delivery mechanism for SBCC (under Component 2), but there will likely be others as well identified through the SBCC strategy and delivered through Component 1.

The food security interventions are linked with the BFCI scale-up. In existing BFCI communities, targeted food security support interventions will be rolled out quickly through input-based financing (i.e. food security-enhanced BFCI under Component 2). In the other communities, BFCI and PHC will be scaled up as the stepping stone for both the delivery of targeted food security interventions as well as community-

based RBF arrangements. In the current community RBF scheme, in order for a community to be contracted, it must have both PHC and BFCI structures in place. Thus, the RBF contracts will be rolled out gradually in a phased manner as an additional layer (under Component 1) on top of the basic food security interventions (under Component 2) to add a financial incentive for communities that achieve specific results using the inputs provided. The PHC and BFCI scale-up supported by the AF in Component 2 will enable more communities to be eligible for the RBF contracts of Component 1. By building on the ongoing activities and existing implementation arrangements, the AF allows expanding the scope of the project at the community level to include food security and scale to include the two new regions.

COMPONENT 3 – Capacity Building for Service Delivery and Results-Based Financing (Total US$3.20 million, including: US$0.90 million AF; US$0.92 million IDA; US$1.38 million HRITF): The additional financing will also support ongoing capacity building for service delivery and RBF at both community and facility levels. The same activities will continue from the original project (capacity building, M&E, coordination and program management at all levels, and performance contracts). However, the scale and intensity will need to be greater due to both the geographic expansion of current activities to two new regions and expansion of scope to now include food security. In the original project, performance contracts were signed with the PIC, NaNA, MOHSW RBF Committee and the RHDs. With the additional food security activities that will be implemented at community level, the AF will also support performance contracts with the Regional Agriculture Directorates (RAD) for monitoring and oversight, which will require capacity building of RADs.

COMPONENT 4 – Ebola Preparedness and Control (Total US$0.50 million IDA): In the earlier restructuring of this project, US$0.50 million was reallocated to support implementation of immediate actions in the Ebola Response Plan under Component 4. Specifically, social mobilization (e.g. development and distribution of communication materials) and case management (e.g. health care worker training and preparedness, provision of personal protective equipment) are being supported. The activities are being supported by WHO through a Memorandum of Understanding (MOU) for technical assistance. The MOU was signed on February 5, 2015. No additional financing will be allocated for Component 4.

Current Component Name	**Proposed Component Name**	**Current Cost (US$M)**	**Proposed Cost (US$M)**	**Action**
Community mobilization for social and behavior change	Community mobilization for social and behavior change	2.35	4.15	Revised
Delivery of selected primary health care services	Delivery of community nutrition and primary health care services	3.53	5.83	Revised
Capacity building for service delivery and results based financing	Capacity building for service delivery and results based financing	2.30	3.20	Revised
Ebola preparedness and control	Ebola preparedness and control	0.50	0.50	No Change
	Total:	8.68	13.68	

Other Change(s)		
Implementing Agency Name	**Type**	**Action**
National Nutrition Agency (NaNA)	Implementing Agency	No Change

Change in Institutional Arrangements

Explanation:

The implementation arrangements for the AF will undergo only minor changes from those for the current project. At the *central level*, the arrangements remain largely the same with two modifications. First, the Ministry of Agriculture will be added to the Steering Committee. Second, the MOHSW will manage the additional Ebola financing with activities implemented through the National Ebola Task Force (in MOHSW) and oversight from the MOHSW RBF Committee. The National Nutrition Agency (NaNA) and the MOHSW will remain the implementing agencies of the project and will continue to implement the project jointly through the Project Implementation Committee (PIC), composed of NaNA and MOHSW staff. At the *regional level*, both MOHSW and NaNA work through the RHDs to oversee community mobilization and service delivery. A new actor at this level will be the Regional Agriculture Directorate (RAD) which will be mobilized to assist with the oversight of the food security interventions through a performance contract with NaNA.

For Component 1, the RHDs continue as the purchaser of community results through: (i) RBF contracts with the Village Development Committee (VDC) for maternal and child nutrition and health results, including food and nutrition security indicators, in the five target Regions; and (ii) CCTs to individual women to increase utilization of timely antenatal care. The accompanying SBCC measures aimed at promoting behavior change and increasing demand to improve household practices related to health and nutrition will continue to be implemented through the existing arrangement using input-based financing. Given NaNA's mandate on multi-sectoral food and nutrition security at community-level, it is well-positioned to ensure that food security messages are well integrated into the SBCC strategy.

For Component 2, the MOHSW RBF Committee continues as the purchaser of health service delivery results through a PBF mechanism to health centers for the delivery of a predefined package of maternal and child health and nutrition services at primary and referral health care facilities. The provision of startup support for effective service delivery (including the implementation of selected health care waste management measures) to PBF facilities as well as the food security enhanced BFCI and PHC scale up will be implemented through the existing arrangement using input-based financing. The pilot in NBR-W has provided experience working with regional directorates (for health) through performance contracts (under Component 3) on which performance contracts with the RADs will be modeled. NaNA will provide capacity building to the RADs to improve their understanding of the performance-based mechanism to ensure their full participation, and performance indicators will be selected based on current and desired future capacity.

The changes in implementation arrangements emanating from the proposed changes in activities are summarized here and are presented in a schematic in Annex 3:
a. *Central level*: the Ministry of Agriculture will be added to the Steering Committee, which oversees the implementation of the Project, and is currently composed of Ministry of Finance and Economic Affairs (MOFEA), MOHSW, NaNA, the Office of the Vice President, and the Ministry of Regional Government, Land and Traditional Rulers. The MOHSW will manage the additional Ebola financing while activities

will be implemented through the National Ebola Task Force (in MOHSW) with oversight from the MOHSW RBF Committee.

b. *Regional level*: as part of Component 3, NaNA will sign performance contracts with the RAD to provide advisory, veterinary and oversight services to communities for the food security interventions.

Change in Financial Management

Explanation:

The AF will use parallel financing by category between the IDA Grant and IDA Credit such that for each category in the disbursement table, the Grant proceeds would be fully exhausted before the Credit proceeds are used.

The AF will use the financial management arrangements of the current project. The recipient will, however, take the following actions: (i) customize the existing "multi projects" computerized accounting system to fit the needs of the AF, (ii) open a Designated Account, (iii) revise the terms of reference of the current project's External Auditor to include the proposed Additional Financing activities. The recipient should join to its applications for withdrawal a statement of expenditure (SoE) summarizing eligible expenditures paid. The implementing agency does not have an overdue audit report and the financial management performance of the current project was rated satisfactory during the implementation support mission in September 2014.

The Country Portfolio Performance Review (CPPR) on May 2, 2013 decided that all new Projects must use the GIFMIS. However, the Recipient has informed the Bank that, technically, they are unable to roll out the GIFMIS to NaNA by fifteen (15) months after effectiveness as previously announced. An estimate of when GIFMIS technical issues will be resolved and GIFMIS rolled out to NaNA is uncertain. Therefore, the dated covenant in the original FA on the use of GIFMIS as the Project's financial information system within fifteen (15) months after Effective Date is annulled.

Change in Procurement

Explanation:

Procurement activities will be conducted using the existing institutional arrangements for the implementation of the ongoing MCNHRP with the following management setup: NaNA will be the fundholder while MOHSW and RHDs will act as the regulators. Accordingly, NaNA will be responsible of all procurement activities and is currently sufficiently staffed in the Procurement Section to handle procurement activities brought by the AF. The project management team is familiar with IDA procedures and has handled procurement under the current IDA project as well as for other donor-supported operations. NaNA has performed satisfactorily over the past six years, and the experience and the expertise that has developed in NaNA is expected to greatly benefit the arrangement of the AF.

NaNA has updated the POM to take into account the AF and developed a Procurement Plan for the

first 18 months of the AF. The following guidelines apply to the AF: (i) "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants, dated October 15, 2006 and revised in January 2011; (ii) "Guidelines Selection and Employment of Consultants under IBRD Loans and IDA Credits ant Grants by World Bank Borrowers" published by the Bank in January 2011 revised July 2014; and (iii) "Guidelines: Procurement of Goods, Works and Non-consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers" published by the Bank in January 2011 revised July 2014.

IV. Appraisal Summary

Appraisal Summary
Economic and Financial Analysis
Explanation: The AF is expected to (a) alleviate food and nutrition insecurity, save lives, and improve health service utilization in the short-term, and (b) increase community resilience to agriculture shocks in the medium-term with enormous economic and social benefits. The investments have high development impact and are operationally efficient. The economic analysis supporting this conclusion follows. DEVELOPMENT IMPACT: FOOD AND NUTRITION SECURITY INTERVENTIONS Interventions financed by the AF will lead to the targeting of resources to the most vulnerable segments of society. The specific high-impact interventions benefiting young children, adolescents and pregnant women are known to help improve the chances of these sub-populations to rise out of poverty and contribute to the growth of the economy through higher labor productivity as adult workers. These economic benefits have been documented in economic and scientific studies in many developing countries. Estimates from a number of studies in the last 20 years indicate that the economic returns of nutrition interventions (including growth monitoring, micronutrient supplementation, salt iodization, etc.) rank among the highest in comparison with other developmental interventions. These results are achieved by the high productivity-enhancing effects of nutrition programs. Iron supplementation for example improves worker productivity, and iodine improvements increase cognitive ability (higher IQ) of children and adults. The 2008 and 2012 Copenhagen Consensus by some of the world's leading economists that looked at the best investments concluded that nutrition investments, notably micronutrients and community nutrition, generate returns among the highest of 30 potential development investments. Investments in micronutrients were rated above those in trade liberalization, malaria and water and sanitation. Community-based programs are also cost-effective in preventing malnutrition. Overall the benefit-cost ratios for nutrition interventions range from 5 to 200. With the above in mind, the economic analysis that was undertaken for the original project was updated to account for the additional beneficiaries and interventions covered by the AF. The direct beneficiaries are children under the age of 5, adolescent girls, and pregnant women in URR, CRR, LRR, NBR-E and NBR-W. To avoid double-counting benefits (e.g. those that accrue

intergenerationally, adolescent girls who become pregnant during the course of the project), the cost-benefit analysis was restricted to benefits gained by children under age 5 years only. Benefits to adolescent girls and women of reproductive age (15-49) who will benefit from improved reproductive and maternal health are not included. This implies that the estimated benefits are underestimated.

The analysis focuses on stunting because chronic undernutrition is an indicator of the final nutritional status of children according to the UNICEF conceptual framework. Evidence indicates that children under the age of 24 months who are stunted would earn significantly lower incomes throughout their productive lives. Thus, the benefits of reducing stunting in the project areas are measured by the increased income-earning capacity of the beneficiaries for whom stunting is prevented. The most recent empirical estimates of the negative effects of stunting on worker productivity and adult earnings range from 10 to 20 percent.

Assuming 80 percent project coverage, 15 percent earnings premium from reduced stunting after accounting for expected mortality risk, no effect on stunting for better-off households, and 5 percent discount rate, the results of this economic analysis yields a net present value (NPV) of US$1.5 million and Benefit/Cost (B/C) ratio of 2.0. A sensitivity analysis was conducted to assess robustness of the estimates. In Scenario 2, the earnings premium due to stunting, were increased from 15 to 20 percent (as estimated by Grantham-McGregor and colleagues) which yields an NPV of US$2.5 million and a B/C ratio of 2.7. In Scenario 3, the earnings premium is reduced to 10 percent which yields an NPV of US$0.5 million and a B/C ratio of 1.3. Thus, the CBA indicates that the food and nutrition security interventions are a sound economic investment that yield high benefits even in the conservative scenario.

DEVELOPMENT IMPACT: DELIVERY OF PRIMARY HEALTH CARE SERVICES AND HEALTH SYSTEM STRENGTHENING

Addressing maternal and reproductive health brings dividends in both the short and long terms. The package of services included in the Project is technically sound and consistent with The Lancet's recommendations on priority, high-impact interventions to reduce child and maternal mortality rates. Pregnancy-related conditions and sexually transmitted infections account for one-third of the global burden of disease among women of reproductive age, and in Sub-Saharan Africa, two-thirds of the disease burden for women of reproductive age is attributable to sexual and reproductive health problems. Delaying first birth and spacing subsequent births result in a higher likelihood of women staying in, having more employment opportunities, and participating politically in their communities. Improved maternal health means fewer orphans and more time for and greater ability of mothers to provide appropriate childcare. One of the most cost-effective interventions is family planning (US$1.55 per new user per year) which can prevent up to one-third of all maternal deaths by delaying childbearing, spacing births, avoiding unintended pregnancies. Family planning can also reduce infant mortality and morbidity through birth spacing and improve adolescent health by reducing high risks of pregnancy-related deaths. For every US$1 invested in family planning, the future savings are as high as US$4 in Zambia, US$7 in Bangladesh and US$8 in Indonesia. Hence, the returns on investment are high especially when integrated with maternal and child health services as in this project.

The cost effectiveness and return on investment for the delivery of primary health care services

and overall health system strengthening were analyzed based on core interventions that will be introduced under the AF. The bulk of these resources will go to health facilities under performance-based contracts for the delivery of packages of health services, the management and TA necessary to enable them to deliver the services. The MBB analysis outlines the cumulative effect of per capita investments in prioritized interventions. Extrapolation from the broader analysis allows conclusions to be drawn regarding the economic benefits of the financing on key prioritized interventions noted in the government's Health Sector Investment Case.

The Investment Scenario requires that in order to reduce under-five and maternal mortality by 17.14 percent and 10.38 percent, respectively, an additional investment of US$2.71 per capita per year is required on average. The conclusion is that the benefits from the US$1.95 per capita per year investment from the project (over 5 years to men, women and children) significantly outweigh the costs of retaining the status quo. The project investments in PHC service delivery and health system strengthening can be expected to bring about reductions in child and maternal mortality by 12.3 percent and 7.5 percent, respectively.

Furthermore, The Gambia has been on alert to the recent epidemic of Ebola in the region and has recently been categorized as one of eight countries at "very high risk" for an Ebola outbreak in the next few months. Without adequate preparation and mitigation efforts, an Ebola outbreak in The Gambia would have devastating health and economic consequences. It would stall economic activity and profoundly disrupt the social fabric of society. In The Gambia, this economic effect has already been felt even without any confirmed cases – news from the sub-region has deterred tourists leading to massive cancellations (of nearly 75%) in the tourism industry. Spread of the Ebola epidemic to The Gambia would make a fragile health system even more vulnerable and prohibit working with communities, therefore paralyzing project implementation. The activities included in the previous restructuring were aimed at improving knowledge about the disease, reducing fear, and improving the country's preparedness to respond to any cases. The activities in the AF would further strengthen the health system to improve surveillance capacity.

The delivery of primary health care services and health system strengthening (including for Ebola preparedness), combined with the implementation of the food and nutrition security interventions, will further amplify the health and nutrition benefits gained. Similar amplification is anticipated with the complementary and strategic use of RBF and non-RBF mechanisms.

EFFICIENCY

The majority of the financing for Component 1 is allocated to two main activities: (a) community RBF contracts, and (b) social and behavior change communication. The incremental cost of adding food security to both of these activities is marginal. On the community RBF, the AF will support expanding the current incentivized indicators to include food security indicators – e.g. percent of vulnerable households in the community with backyard gardens. Monitoring and verification of these results would be done using similar tools and methods as is currently being done, and data would be collected simultaneously for all the community indicators. With respect to SBCC, the topic of food security would be mainstreamed into the SBCC strategy that is currently under development. The marginal cost of integrating it into the strategy and implementing it at the community level in an integrated manner would be minimal.

Adding food security interventions to the BFCI scale-up will be operationally efficient for three reasons: (i) multisectoral action at community level is already part of the project, notably through environmental hygiene and sanitations and integrating health and nutrition with the participation of community level actors mobilized during a previous Community Driven Development project; (ii) the food security interventions require minimal involvement of additional implementing institutions as these are already part of NaNA's mandate; and (iii) domestic and community action for food diversification is part of NaNA's community nutrition program.

Technical Analysis

Explanation:

The proposed approach under the Additional Financing builds on the latest evidence on promoting food security for improved child nutrition, including the enhanced homestead food production model by Helen Keller International in Burkina Faso, the use of quick-to-prepare fortified porridges and targeted complementary feeding of animal protein by Alive and Thrive in Bangladesh and Ethiopia; the USAID | Yajeende (Feed the Future) Nutrition-led Agriculture Project and the targeted Food Security Support and Nutrition Enhancement Project for Vulnerable Households in Senegal; and the FICA-FAO Improving Food Security and Nutrition Project in Malawi. All these experiences have in common that where food insecurity is a major constraint, the promotion of diversified household food production as part of an Infant and Young Child Feeding (IYCF) promotion strategy can overcome persistent barriers in the prevention of malnutrition. The key principle is that the promotion of household-level food production and diversification is an integral part of the nutrition education activities aimed at the improvement of mother and child nutrition. The integral focus on nutrition (or nutrition-led agriculture) is an important departure of the stand-alone promotion of diversified food production projects which have shown to be ineffective in improving nutrition outcomes. Finally, the targeting of vulnerable households is a common feature in most of these experiences as a way to enhance the efficacy of the interventions.

The proposed approach of addressing household food security issues as part of an integrated approach for health and nutrition promotion also follows the latest guidance on linking agriculture and nutrition as well as the findings in the 2014 Global Nutrition Report on significant and sustained improvements in nutrition by combining nutrition-specific with nutrition-sensitive actions that include the food supply, hygiene and sanitation, and availability of health care. The MCNHRP will focus on commercially-viable, small-scale food production, transformation, conservation and utilization at the household level to contribute to improved food and nutrition security as opposed to the traditional vertically organized agricultural productivity programs. This multi-sectoral response will focus on the most vulnerable households and enhance community and household resilience to food and nutrition insecurity shocks. The identification of the most vulnerable households will use a combination of categorical and community targeting to identify eligible beneficiaries (mothers of young children in vulnerable families), who will receive support for the small-scale food security interventions.

The proposed multi-sectoral response builds on the positive experiences with results-based financing (RBF) in education, health and nutrition to strengthen efficacy, efficiency and ownership. The education sector has been implementing an RBF approach and has seen results in

improved school enrolment and quality of teaching. While the MCNHRP has only been effective since May, a pilot has been implemented in the North Bank West Region, and process evaluation results indicate an increased uptake in maternal and child health and nutrition services (e.g. institutional deliveries) and improved quality of care (e.g. shift from unskilled to skilled health workers attending deliveries in health facilities).

Finally, the Ebola epidemic in West Africa has served as a wake-up call on the importance of investing in disease surveillance, well-trained and protected staff, and laboratory systems. Following the initial restructuring which focused on supporting the implementation of immediate actions in the Ebola response plan, the additional financing will support health systems strengthening efforts to improve Ebola preparedness and control measures. Activities would focus on improving data and information systems and laboratory capabilities. Country ownership is critical and the MOHSW has demonstrated strong leadership for respective technical working groups, and rallying the different stakeholder behind on national Ebola response plan. Activities will be implemented by the National Ebola Task Force which regroups all stakeholders in the Ebola response plan.

Social Analysis

Explanation:

Women and children are particularly vulnerable to both food and nutrition insecurity and Ebola. The most vulnerable people to food and nutrition insecurity shocks are women and children. According to the 2014 gender assessment by the World Bank, women are disadvantaged economically within the household, women in better-off households fare better, and women seem to have some control (albeit a small amount) over their own income. The assessment also found that while women generally have limited control over resources, they play essential roles in the production of food, the consumption in the household and the reproduction of the family. Therefore, the immediate beneficiaries will be women and children in food and nutrition insecure households and communities. In addition, according to WHO, two of the three largest outbreaks of Ebola involved transmission in maternity settings. In the most recent outbreak, as health care workers have become increasingly affected, maternal and child health services become limited. Women have not had access to skilled care during delivery, immunizations and child health care have been put on hold, and the most vulnerable members in communities have been further marginalized. Furthermore, women, often as primary caregivers in homes and in health facilities, have been disproportionately affected, indicating that Ebola has a strong gender dimension. Thus, the restructuring is necessary as a mitigating effort to prevent additional vulnerabilities to women and children and hence no social safeguards have been triggered.

Environmental Analysis

Explanation:

New activities implemented would not modify the safeguard arrangements of the original Project, which had triggered the Environmental Assessment policy OP4.01 due to the potential for increased medical waste and is being mitigated by a new nationally validated Health Care Waste Management Plan (HCWMP). The HCWMP was publicly disclosed in country on January 30, 2014 and in the Infoshop on January 22, 2014 under the original project. In addition, since the project became effective on May 20, 2014, Standard Operating Procedures (SOPs) have been

developed to accompany the HCWMP, a training done with health workers on the SOPs, and a Health Care Waste Management Policy has been developed and adopted by the MOHSW, all of which have been found to be acceptable by the Bank. The new food security activities refer to small-scale, household- and community-based interventions that do not trigger OP4.01 on environmental assessment. The new Ebola prevention and control activities is not expected to increase the production of medical wastes beyond the original project, and the expansion of RBF activities to other regions do not trigger additional safeguards – both are adequately covered by the HCWMP and would reinforce ongoing implementation of the HCWMP. The HCWMP and the HCWM Standard Operating Procedures have been disclosed for the AF both in-country (February 24, 2015) and in the Info-Shop (March 2, 2015).

The project has already contributed to improved policies and procedures for health care waste management, and the proposed changes in the AF are not expected to have any significant or irreversible environmental or social impacts. In fact, the activities (information, education and communication; improvement of food and nutrition security; health care worker training; provision of personal protective equipment) would have positive environmental and social impacts by supporting and strengthening communities and the health system. Implementation of the HCWMP was discussed and agreed with the client and will be closely monitored during project supervision. The ISDS has been updated to reflect the additional financing.

Risk

Explanation:

The overall risk continues to be rated as substantial as discussed in the SORT (Annex 4). The original risks remain relevant and include political and governance (the instability around concerted implementation of health policies and programs in the health sector as a result of high staff turn over both at the central and operational levels); macroeconomic (fiscal policies need much improvement); technical design of project (the introduction of a new approach to health financing through RBF and innovative design features such as demand-side and community-based incentives); and fiduciary (including the need for close inter-institutional coordination with two government agencies involved in the implementation). The Gambia is prone to political instability, as indicated by a recent coup attempt in December. However, the additional financing does not add any major risks and the risks remain the same as the original project – implementation arrangements remain unchanged and the implementing agencies have experience with the implementation of food and nutrition security interventions.

Climate Screening

Explanation:

Applying the climate and disaster risks screening tool indicates that the primary climate and geophysical hazards that may impact project impact are shorter and more erratic rainy seasons in the future. The food security interventions are designed to help mitigate this with interventions to address household food insecurity in the immediate term and efforts to build resilience in the medium- to long-term.

V. World Bank Grievance Redress

26. 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: Revised Results Framework and Monitoring

THE GAMBIA: Additional Financing (P154007) – Maternal and Child Nutrition and Health Results Project (P143650)

Revisions to the Results Framework		**Comments/ Rationale for Change**
PDO		
Current (PAD)	*Proposed*	
To increase the utilization of community nutrition and primary maternal and child health services in selected regions in the Recipient's territory	No change	
PDO indicators		
Current (PAD and Restructuring Paper)	*Proposed change**	
PDO#1: Children 0-6 months exclusively breastfed (percent)	No change	
PDO#2: Deliveries attended by certified midwives in the preceding year (number)	Target revised	Target increased to 17,500
PDO#3: Children between the age of 6 and 59 months receiving Vitamin A supplementation (number)	Dropped	Indicator is repeated as Core indicator under Component 1
PDO#3: Children age 6-23 months consuming at least four out of six food groups (%)	New	This indicator reflects new activities on promotion of food and nutrition security
PDO#4: Women using modern methods of family planning (number)	Target revised	Target increased to 20,000
PDO#5: Direct project beneficiaries (number)	Target revised	**Core indicator:** Target increased to 700,000
PDO#5a: Female beneficiaries (percent)	No change	
Intermediate Results indicators		
Current (PAD)	*Proposed change**	
IOI#1: Pregnant women referred by VSG members for delivery and complication management (number)	Target revised	Target increased to 12,000
IOI#2: Hand washing stations/points established (number)	Target revised	Target increased to 5,000
IOI#3 Community registers updated quarterly (number)	Target revised	Target increased to 560
IOI#4: Pregnant/lactating women, adolescent girls and/or children under age five-reached by basic nutrition services (number)	Target revised	**Core indicator:** Target increased to 593,000
IOI#5: Children between the age of 6 and 59 months receiving Vitamin A supplementation (number)	Target revised	**Sub-Core indicator:** Target increased to 475,000
IOI#6: Pregnant women receiving iron and folic acid (IFA) supplements (number)	Target revised	**Sub-Core indicator:** Target increased to 18,000
IOI#7: Children under the age of 24 months benefiting from improved infant and young child feeding (IYCF) practices (number)	Target revised	**Sub-Core indicator:** Target increased to 95,000
IOI#8: Children under age five treated for moderate	Target revised	**Sub-Core indicator:** Target increased to

Revisions to the Results Framework		Comments/ Rationale for Change
or severe acute malnutrition (number)		5,000
IOI#9: BFCI villages in the selected regions (number)	New	This indicator reflects new activities in scaling up BFCI
IOI#10: Children 12-59 dewormed in the preceding year (number)	Target revised	Target increased to 46,000
IOI#11: Pregnant women coming for ANC in the first trimester in the preceding year (number)	Target revised	Target increased to 5,900
IOI#12: Post-partum mothers supplemented with VAS in the preceding year (number)	Target revised	Target increased to 26,000
IOI#13: Vulnerable households supported in participating in gardening or keeping ruminants or poultry in intervention areas (number)	New	This indicator reflects new activities on promotion of food and nutrition security
IOI#14: Communities supported in establishing child food banks (number)	New	This indicator reflects new activities on promotion of food and nutrition security
IOI#15: Health workers (including central and regional level managers) trained on RBF management (number)	Target revised	Target increased to 200
IOI#16: RBF adopted in the revised health financing policy (Y/N)	No change`	
IOI#17: Health personnel receiving training (number)	Target revised	**Core indicator:** Target increased to 460
IOI#18: Health personnel trained on Ebola prevention and management (number)	No change	

Project Name:	GM Maternal and Child Nutrition and Health Results Project (P154007)			Project Stage:	Additional Financing
Status:	DRAFT				
Team Leader(s):	Rifat Hasan	Requesting Unit:	AFCF1	Created by:	Aissatou Chipkaou on 22-Jan-2015
Product Line:	IBRD/IDA	Responsible Unit:	GHNDR	Modified by:	Rifat Hasan on 13-Mar-2015
Country:	Gambia, The	Approval FY:	2015		
Region:	AFRICA	Lending Instrument:	Investment Project Financing		
Parent Project ID:	P143650	Parent Project Name:	Maternal and Child Nutrition and Health Results Project (P143650)		

Project Development Objectives

Original Project Development Objective - Parent:

A. Proposed Development Objective

The development objective of the project is to increase the utilization of community nutrition and primary maternal and child health services in selected regions in the Recipient's territory.

Proposed Project Development Objective - Additional Financing (AF):

The development objective of the project is to increase the utilization of community nutrition and primary maternal and child health services in selected regions in the Recipient's territory.

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
No Change	Children 0-6 months	☐	Percentage	Value	47.00		60.00

	exclusively breastfed[1]			Date	31-Dec-2013		31-Jul-2019
				Comment			
Revised	Deliveries attended by certified midwives in the preceding year	☐	Number	Value	8885.00		17500.00
				Date	31-Dec-2013		31-Jul-2019
				Comment			
Marked for Deletion	Children between the age of 6 and 59 months receiving Vitamin A supplementation	☐	Number	Value	0.00	62174.00	385000.00
				Date	28-Feb-2014	30-Sep-2014	31-Jul-2019
				Comment			
New	Children 6-23 months consuming at least four out of six food groups	☐	Percentage	Value	19.00		30.00
				Date	31-Dec-2013		31-Jul-2019
				Comment			
Revised	Women using modern methods of family planning[2]	☐	Number	Value	12925.00		20000.00
				Date	31-Dec-2013	30-Sep-2014	31-Jul-2019
				Comment			
Revised	Direct project beneficiaries	☒	Number	Value	0.00		700000.00
				Date	28-Feb-2014		31-Jul-2019
				Comment			
No Change	Female beneficiaries	☒	Percentage Sub Type Supplemental	Value	70.00		70.00

Intermediate Results Indicators

Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
Revised	Pregnant women referred by VSG members for delivery and	☐	Number	Value	0.00		12000.00
				Date	28-Feb-2014		31-Jul-2019

	complication management			Comment			
Revised	Hand washing stations/points established	☐	Number	Value	0.00	0.00	5000.00
				Date	28-Feb-2014	05-Dec-2014	31-Jul-2019
				Comment			
Revised	Community registers updated quarterly	☐	Number	Value	341.00	341.00	560.00
				Date	31-Jan-2014	05-Dec-2014	31-Jul-2019
				Comment			
Revised	Pregnant/lactating women, adolescent girls and/or children under age five-reached by basic nutrition services (number)	☒	Number	Value	90000.00		593000.00
				Date	31-Jan-2014		31-Jul-2019
				Comment			
Revised	Children between the age of 6 and 59 months receiving Vitamin A supplementation (number)	☒	Number Sub Type Breakdown	Value	70000.00		475000.00
				Date	31-Jan-2014		31-Jul-2019
				Comment			
Revised	Pregnant women receiving iron and folic acid (IFA) supplements (number)	☒	Number Sub Type Breakdown	Value	9000.00		18000.00
				Date	31-Jan-2014		31-Jul-2019
				Comment			
Revised	Children under the age of 24 months benefiting from improved infant and young child feeding (IYCF) practices (number)	☒	Number Sub Type Breakdown	Value	10000.00		95000.00
				Date	31-Jan-2014		31-Jul-2019
				Comment			
Revised	Children under age five treated for moderate or severe acute malnutrition (number)	☒	Number Sub Type Breakdown	Value	200.00		5000.00
				Date	31-Jan-2014		31-Jul-2019
				Comment			
Marked for	Pregnant/lactating women,	☒	Number	Value	0.00		33000.00

Deletion	adolescent girls and/or children under age five- reached by basic nutrition services – Others (specify)		Sub Type Breakdown	Date	31-Jan-2014		31-Jul-2019
				Comment			
New	Communities implementing BFCI activities	☐	Number	Value	633.00		1100.00
				Date	11-Mar-2015		31-Jul-2019
				Comment			
Revised	Children 12-59 dewormed in the preceding year	☐	Number	Value	6461.00		46000.00
				Date	31-Dec-2013		31-Jul-2019
				Comment			
Revised	Pregnant women coming for ANC in the first trimester in the preceding year	☐	Number	Value	2342.00		5900.00
				Date	31-Dec-2013		31-Jul-2019
				Comment			
Revised	Post-partum mothers supplemented with VAS in the preceding year	☐	Number	Value	22200.00		26000.00
				Date	31-Dec-2013		31-Jul-2019
				Comment			
New	Vulnerable households supported in participating in gardening, keeping ruminants, or keeping poultry	☐	Number	Value	0.00		3000.00
				Date	26-Feb-2015		31-Jul-2019
				Comment			
New	Communities supported in establishing child food banks	☐	Number	Value	0.00		250.00
				Date	09-Feb-2015		31-Jul-2019
				Comment			
Revised	Health workers (including central and regional level managers) trained on RBF management	☐	Number	Value	38.00	207.00	200.00
				Date	31-Jan-2014	05-Dec-2014	31-Jul-2019
				Comment			

No Change	RBF adopted in the revised health financing policy	☐	Yes/No	Value	No	No	Yes
				Date		05-Dec-2014	
				Comment			
Revised	Health personnel receiving training (number)	☒	Number	Value	0.00	0.00	460.00
				Date	28-Feb-2014	05-Dec-2014	31-Jul-2019
				Comment			
No change	Health personnel trained on Ebola prevention and management	☐	Number	Value	0.00		100.00
				Date	11-Nov-2014		31-Jul-2019
				Comment			

[1] Baseline is the national figure from the DHS 2013

[2] These are quarterly totals which include double counting of women using short term methods. The assumption is that the method mix will not change as a result of the project. Trends will be monitored and action will be taken if assumption proves to be wrong.

Annex 2: Detailed Project Description

1. The additional financing will support food and nutrition security activities, the replenishment of the reallocation and additional support for Ebola response activities, and the expansion of original project activities in the MCNHRP (P143650). The MCNHRP is currently being scaled up in the western half of North Bank Region (NBR-W), the Central River Region (CRR) and Upper River Region (URR). The additional financing would support new areas in the eastern half of North Bank Region (NBR-E) and Lower River Region (LRR) which have a total population of approximately 200,000 to be added to the MCNHRP. Overall, the components will be as indicated in Table 2.1, with the changes with additional financing italicized:

Table 2.1: Summary of activities by component

Component 1: Community Mobilization for Social and Behavior Change	• Conditional cash transfers to communities and support groups *scale-up to NBR-E and LRR* • Conditional cash transfer to individuals *scale-up to NBR-E and LRR* • Social and behavior change communication (SBCC) *scale-up to NBR-E and LRR*
Component 2: Delivery of Community Nutrition and Primary Health Care Services	• Performance-based financing for health centers *scale-up to NBR-E and LRR* • Start-up support, including selected health care waste management measures *scale-up to NBR-E and LRR* • *Ebola preparedness and control* (*surveillance)* • PHC scale-up *to NBR-E and LRR* • *Food security-enhanced* BFCI *scale-up to NBR-E and LRR*
Component 3: Capacity Building for Service Delivery and RBF	• Capacity building • M&E, operational research and verification • Coordination and program management at all levels • Performance contracts with RHD, *RAD,* RBF Committee, and NaNA
Component 4: Ebola preparedness and control	• Social mobilization and case management

2. **Component 1 – Community Mobilization for Social and Behavior Change** (Total US$4.15 million, including: US$1.80 million AF; US$0.91 million IDA; US$1.44 million HRITF): This component currently supports: (i) results-based financing contracts with communities and VSGs to increase demand for and utilization of health and nutrition services through counseling and timely referrals for life-saving health services (e.g., hygiene, sanitation, counseling on infant and young child feeding, delayed first pregnancy and child spacing, referral of pregnant women and children with danger signs to health centers); (ii) conditional cash transfers (CCT) to individual women to increase utilization of timely antenatal care; and (iii) accompanying measures aimed at promoting behavioral changes and increasing demand to improve household practices related to health and nutrition through social and behavior change communication (SBCC; which includes technical advisory services and training).

3. The proposed change to this component is to expand the scope of the community agreements and the accompanying measures to include food security indicators and messages. The additional indicators and messages will relate to the expanded service delivery activities described under Component 2 and cover off-season and diversified food production of vegetables, fruits, ruminants and poultry by vulnerable households, use of improved vegetable seed and ruminant/poultry race varieties, use of improved (staple) food storage facilities, adoption of appropriate food transformation technologies, the establishment of emergency food banks at community level, diversified food intake, the commercialization of excess production, and increased plot allocation for small-scale food production to women in vulnerable households. The community contracts will be gradually expanded to the two additional Regions, NBR-E and LRR, similarly to the expansion in the original Regions by adding batches of a manageable number of community contracts. Examples of food security indicators for the community contracts are: percentage of beneficiary households effectively supported with gardening, fruit tree planting or keeping rudiments or poultry; number of households having difficulty to provide a daily meal; number of vulnerable households supported to establish model storage facilities; number of households supported with appropriate food transformation technologies; percentage of children 6 to 59 months consuming at least four out of six food groups; percentage of community gardens producing at least six types of vegetables; establishment of an emergency food insurance bank. The accompanying measures which refer to comprehensive SBCC strategies will be scaled up to all communities of the five Project Regions.

Component 2 – Delivery of Community Nutrition and PHC Services (Total US$5.83 million, including: US$2.30 million AF; US$1.35 million IDA; US$2.18 HRITF): This Component currently supports the delivery of nutrition and primary health care services through (i) performance-based financing (PBF) grants to health centers for the delivery of a predefined package of maternal and child health and nutrition services at primary and referral health care facilities; and (ii) startup support for effective service delivery, including the implementation of selected health care waste management measures. This package is being implemented in NBR-W, CRR and URR. The proposed changes to this component are:
(a) PBF package (as described above) expansion to NBR-E and LRR;
(b) Ebola preparedness and control
(c) PHC scale-up extended to NBR-E and LRR in support of the current MOHSW strategy; and
(d) Food security-enhanced BFCI scale-up across the five regions.

4. *PBF Package Expansion:* The above package is being implemented in 24 health facilities in NBR-W, CRR and URR, and the additional financing will expand this to include another 13 facilities across NBR-E and LRR. Health facilities sign a PBF contract with the MOHSW RBF Committee and receive quarterly payments corresponding to their achieved performance. A fee-for-service mechanism, including quantity and quality payments, is being employed with payments triggered following quantity verification by NaNA. The final amount is determined following quality verification by RHDs. Health facility can use their payments for material and equipment, training, consulting services and operating costs, and staff bonuses that will ultimately improve service delivery. Facilities have sufficient decision space for social entrepreneurship to use the performance payments to improve the demand and quality of services provided. As part of the RBF contracting cycle, each health facility develops a business plan which serves as a guide for future investments and use of payments.

5. *Ebola Preparedness and Control:* The AF will provide US$0.25 million to support health system strengthening efforts to improve Ebola preparedness and control. Activities will address strengthening the data management system (e.g. review of and training on Integrated Disease Surveillance and Response, procurement of data cards to expand reliable internet access at regional level and health facilities) and improving the reporting system (e.g. training of health care workers on reporting, monitoring and supervision). The AF is focusing on broader health system strengthening that is relevant to not only Ebola but other infectious diseases as well.

6. Given the evolving nature of the epidemic risk, the Ebola Response Plan is likely to adapt over the course of the project. Thus, the AF will maintain a degree of flexibility around specific activities to be financed and will support the evolving needs in consultation with the National Ebola Task Force, which coordinates all Ebola activities and is comprised of the government and partners. The project will coordinate closely with the Task Force to ensure that changes in planning are taken into account for implementation of activities. With the restructuring and AF combined, the Bank will support US$0.75 million toward the implementation of the National Ebola Response Plan, which will help the health system not only prepare for a potential epidemic but also mitigate risks to delivery of maternal and child health and nutrition services, thereby contributing to the PDO.

7. *PHC Scale-Up:* The government's Primary Health Care (PHC) Strategy indicates services are to be delivered through three levels of care: (i) the primary level consisting of a network of village health posts of community health workers, (ii) the secondary level consisting of a network of minor and major health centers, and (iii) the tertiary level providing more specialized services and functioning as a referral service for the secondary level. However, financing has increasingly prioritized the tertiary level, resulting in an operationally weakened and under-funded PHC system and inadequate linkages between communities and the health sector. The government has adopted a policy to revitalize PHC, and the current project is supporting this already. The AF in Component 2 will support the PHC scale-up to NBR-E and LRR to strengthen community-level structures and the linkages to health facilities according to agreed-upon criteria for scale-up. Given the early onset of the hungry season, particular focus will be put on the treatment response to active case finding for acute malnutrition. The current coverage of the treatment of severe and moderate acute malnutrition is low and needs to be beefed up through active screening. The PHC scale-up will also facilitate the community-RBF expansion.

8. *Food security-enhanced BFCI Scale-Up:* The Baby Friendly Community Initiative (BFCI) scale-up is supported in the current project. The AF expands the current BFCI scale-up in terms of scope and scale (i.e. expanding to the new regions of NBR-E and LRR). In terms of scope, the AF will support an enhanced version of the BFCI to strengthen local food and nutrition security by building on the experiences of the previous Rapid Response Nutrition Security Improvement Project and the current MCNHRP. Activities that will be added to the BFCI will collectively address both (i) the immediate household food crisis and (ii) medium-term resilience. Activities aimed at the immediate response include: active screening for early signs of malnutrition and provision of treatment at community level for cases of moderate acute malnutrition and through inpatient and outpatient basis at health centers for severe acute malnutrition with our without complications respectively; the targeted promotion and enhancement of off-season diversified household and community food production through

backyard and community gardens; small livestock husbandry; and use of improved seed varieties and animal races. Activities aimed at building resilience at the household and community levels include promotion and use of appropriate food production, storage and transformation technologies; planting of fruit trees and establishment of child-focused community food banks for use during nutritional emergencies. With the recognition that community needs vary, a community diagnostic will be applied to determine feasibility of specific interventions in each community.

9. The most affected regions for food and nutrition insecurity are LRR, NBR, CRR and URR. The most vulnerable people to food and nutrition insecurity shocks are women and children. According to the 2014 gender assessment by the World Bank, women generally have limited control over resources but play essential roles in the production of food, the consumption in the household and the reproduction of the family. Therefore, the immediate beneficiaries of the food security-enhanced BFCI scale-up will be women and children in food and nutrition insecure households and communities. The food-security enhanced BFCI scale up will use community organization structures to identify eligible beneficiaries ((pregnant women and mothers of young children in vulnerable families), who will receive support for the small-scale food security interventions.

10. The targeting of vulnerable households will be done according to the following key processes: (i) setting up of a monitoring committee in each of the food and nutrition insecure Regions identified by the geographic targeting (described in the main document); (ii) setting up of a local (village) selection committee composed of representatives of the VDC, the VSG and community actors; (iii) community-based selection of beneficiaries for small-scale food security interventions based on selection criteria including the mother (or substitute mother) in households with children under five which have difficulty to provide a daily meal complemented by one or two additional easily-measurable criteria (reflective of food vulnerability in the village) to be defined by the village selection committee; (iv) verification and validation of the list of beneficiaries for the small-scale food security interventions.

11. The food security interventions typically involve the following activities; sensitization and mobilization of communities; selection of beneficiary households (see above); community diagnostic to assess feasibility of interventions; development of community regulations on community gardens and community food banks; needs assessment for launching the activities; mobilization and training of village-based social entrepreneurs to ensure provision of inputs on a commercial basis; training of beneficiaries; provision of start-up inputs; monitoring and supervision. The interventions are aimed at supporting mothers of children under five, but will also actively seek male involvement in the community and household activities. The Project will liaise with the necessary extension workers and livestock services through the RAD.

12. Activities in Components 1 and 2 (specifically SBCC and PHC and BFCI scale up) are aimed primarily at bridging the critical gap between communities and the services they need. The SBCC strategy will identify the various barriers, specific target audiences (e.g. women, men, adolescents, religious leaders, etc.), key tailored messages, and appropriate delivery mechanism of the messages to improve demand for and uptake of services. The BFCI scale-up in Component 2 is scaling up the structures required to enable communities to be baby friendly – i.e. establishing and training VSGs. The BFCI will be one delivery mechanism for SBCC (under

Component 2), but there will likely be others as well identified through the SBCC strategy and delivered through Component 1.

13. The food security interventions are linked with the BFCI scale-up. In existing BFCI communities, targeted food security support interventions will be rolled out quickly through input-based financing (i.e. food security-enhanced BFCI under Component 2). In the other communities, BFCI and PHC will be scaled up as the stepping stone for both the delivery of targeted food security interventions as well as community-based RBF arrangements. In the current community RBF scheme, in order for a community to be contracted, it must have both PHC and BFCI structures in place. Thus, the RBF contracts will be rolled out *gradually in a phased manner as an additional layer* (under Component 1) on top of the basic food security interventions (under Component 2) to add a financial incentive for communities that achieve specific results using the inputs provided. The PHC and BFCI scale-up supported by the AF in Component 2 will enable more communities to be eligible for the RBF contracts of Component 1. By building on the ongoing activities and existing implementation arrangements, the AF allows expanding the scope of the project at the community level to include food security and scale to include the two new regions.

14. **Component 3 – Capacity Building for Service Delivery and Results-Based Financing** (Total US$3.20 million, including: US$0.90 million AF; US$0.92 million IDA; US$1.38 million HRITF): The additional financing will also support ongoing capacity building for service delivery and RBF at both community and facility levels. The same activities will continue from the original project (capacity building, M&E, coordination and program management at all levels, and performance contracts). However, the scale and intensity will need to be greater due to both the geographic expansion of current activities to two new regions and expansion of scope to now include food security. In the original project, performance contracts were signed with the PIC, NaNA, MOHSW RBF Committee and the RHDs. With the additional food security activities that will be implemented at community level, the AF will also support performance contracts with the Regional Agriculture Directorates (RAD) for monitoring and oversight.

15. **Component 4 – Ebola Preparedness and Control** (US$0.50 million IDA): In the earlier restructuring of this project, US$0.50 million was reallocated to support implementation of immediate actions in the Ebola Response Plan under Component 4. Specifically, social mobilization (e.g. development and distribution of communication materials) and case management (e.g. health care worker training and preparedness, provision of personal protective equipment) are being supported. The activities are being supported by WHO through a Memorandum of Understanding (MOU) for technical assistance. The MOU was signed on February 5, 2015. No additional financing will be allocated for Component 4.

Annex 3: Detailed Implementation Arrangements

Gambia, The: GM Maternal and Child Nutrition and Health Results Project (P154007)

1. The implementation arrangements for the Additional Financing will undergo minor changes from those for the current project. At the central level, the arrangements remain the same with the NaNA and the MOHSW as the implementing agencies of the project. The MOHSW and NaNA implement the project jointly through the Project Implementation Committee (PIC) composed of NaNA and MOHSW staff. Both MOHSW and NaNA work through the RHD to oversee community mobilization and service delivery. A new actor at this level will be the Regional Agriculture Directorate (RAD) which will be mobilized to assist with the oversight of the food security interventions.

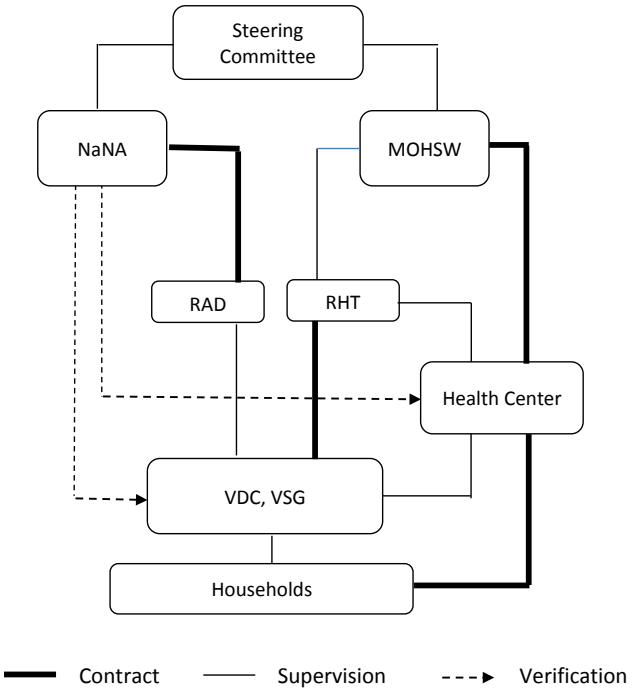
2. For Component 1, the Regional Health Directorates (RHDs) continue as the purchaser of community results through: (i) RBF contracts with the Village Development Committee (VDC) for maternal and child nutrition and health results, including food and nutrition security results, in the five target Regions; and (ii) conditional cash transfers (CCT) to individual women to increase utilization of timely antenatal care. For Component 2, the MOHSW RBF Committee continues as the purchaser of health service delivery results through performance-based grant to health centers for the delivery of a predefined package of maternal and child health and nutrition services at primary and referral health care facilities.

3. The accompanying measures aimed at promoting behavioral changes and increasing demand to improve household practices related to health and nutrition through SBCC (Component 1), the provision of startup support for effective service delivery, including the implementation of selected health care waste management measures to RBF contracted facilities as well as the food security enhanced BFCI and PHC scale up to all and the majority of communities respectively (Component 2) will be implemented through the existing arrangement using input-based financing. NaNA will provide capacity building to the RADs to improve their understanding of the performance-based mechanism to ensure their full participation, and performance indicators will be selected based on current and desired future capacity.

4. The (minor) changes in implementation arrangements emanating from the proposed changes in activities are: (i) at the central level, the Ministry of Agriculture will be added to the Steering Committee, which oversees the implementation of the Project, and is currently composed of MOFEA, MOHSW, NaNA, the Office of the Vice President, and the Ministry of Regional Government, Land and Traditional Rulers; (ii) as part of Component 3, NaNA will sign performance contracts with the RAD to provide advisory, veterinary and oversight services to communities for the food security interventions; (iii) the private sector distributors of agricultural inputs will be linked with community entrepreneurs to provide basic agricultural inputs (implements, seeds, technologies) and advisory services when appropriate; and (iv) the MOHSW will manage the additional Ebola financing while activities will be

implemented through the National Ebola Task Force (in MOHSW) with oversight from the MOHSW RBF Committee. [3]

Figure 3.1: Modified Project implementation arrangements



[3] With the restructuring in December 2014, a new Component (#4) for Ebola Preparedness and Control was added to the project and WHO was added to the implementation arrangement to expedite implementation given the urgency of the situation. The medium-term efforts for health system strengthening for Ebola preparedness and response that will be financed under the Additional Financing will be undertaken by the MOHSW as part of Component 2.

Annex 4: Systematic Operations Risk- Rating Tool (SORT)
Gambia, The: GM Maternal and Child Nutrition and Health Results Project (P154007)
Stage: Additional Financing

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Moderate
6. Fiduciary	Substantial
7. Environment and Social	Low
8. Stakeholders	Moderate
9. Other	
OVERALL	Substantial

Annex 5: Map of The Gambia