

**PROJECT INFORMATION DOCUMENT (PID)
ADDITIONAL FINANCING**

Report No.: PIDA21725

Project Name	GM Maternal and Child Nutrition and Health Results Project (P154007)
Parent Project Name	Maternal and Child Nutrition and Health Results Project (P143650)
Region	AFRICA
Country	Gambia, The
Sector(s)	Health (50%), Other social services (50%)
Theme(s)	Nutrition and food security (40%), Population and reproductive health (20%), Health system performance (20%), Child health (20%)
Lending Instrument	Investment Project Financing
Project ID	P154007
Parent Project ID	P143650
Borrower(s)	The Republic of Gambia
Implementing Agency	National Nutrition Agency (NaNA)
Environmental Category	B-Partial Assessment
Date PID Prepared/Updated	02-Mar-2015
Date PID Approved/Disclosed	04-Mar-2015
Estimated Date of Appraisal Completion	03-Mar-2015
Estimated Date of Board Approval	24-Apr-2015
Appraisal Review Decision (from Decision Note)	

I. Project Context

Country Context

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 2.8 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.

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. 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. Economic growth in The Gambia has not been inclusive. There are large regional variations of poverty within The Gambia, with rural areas recording a substantially higher poverty head count (73.9 percent) compared with urban areas (32.7 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. The 2011-2012 Sahel drought caused big losses in agricultural crop production, with related impacts on household food security and nutrition, the availability of seeds for the following agriculture season, and the balance of payments.

In the last year, The Gambia has been affected by the threat of two potential emergencies. As indicated by the recent 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 50% compared to last year's harvest, and a dramatic increase in food and nutrition insecurity is to be expected in the coming months.

Sectoral and institutional Context

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 include the North Bank Region (NBR) East, Upper River Region (URR), Central River Region (CRR) North and South, and Lower River Region (LRR).

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%).

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). 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.

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 immunity system, making him/her more vulnerable to infectious diseases as well as increased severity of infectious diseases. Malnutrition has persistently been associated with increased risk of infectious diseases such as diarrhea, acute respiratory infections and malaria. Malnutrition in early childhood also irreversibly impairs proper development of the immunity system as well as other functions (e.g., cognitive and physical functions).

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). 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 – that is, 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 to almost half of under-five mortality, 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.

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 above Mali, Niger and Central African Republic but behind countries like Chad, Guinea-Bissau and Nigeria. Total fertility rate (TFR) appears to have 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 118 per 1,000 and nearly 20 percent of adolescent girls age 15-19 having begun childbearing (MICS 2010). 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.

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 emerging 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 Gambia 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.

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. The plan is costed at US\$4.68 million.

II. Proposed Development Objectives

A. Current Project Development Objectives – 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.

III. Project Description

Component Name

Component 1: Community Mobilization for Social and Behavior Change

Comments (optional)

- Conditional cash transfers to communities and support groups
- Conditional cash transfer to individuals
- Social and behavior change communication (SBCC)

Component Name

Component 2: Delivery of Community Nutrition and PHC Services

Comments (optional)

- Performance-based financing for health facilities
- Start-up support, including selected health care waste management measures
- Ebola preparedness and control
- PHC scale-up
- Food security-enhanced BFCI scale-up

Component Name

Component 3: Capacity Building for Service Delivery and Results-Based Financing

Comments (optional)

- Capacity building
- M&E, operational research and verification

- Coordination and program management at all levels
- Performance contracts with RHT, RAD, RBF Committee, and NaNA

IV. Financing (in USD Million)

Total Project Cost:	5.00	Total Bank Financing:	5.00
Financing Gap:	0.00		
For Loans/Credits/Others			Amount
BORROWER/RECIPIENT			0.00
International Development Association (IDA)			5.00
Total			5.00

V. Implementation

With a separate grant of US\$850,000 from the Multi-Donor Trust Fund for Health Results Innovation, 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 while it has decreased in a comparison non-pilot area. 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 community action for improved health and nutrition outcomes by including household food security concerns.

VI. Safeguard Policies (including public consultation)

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

Comments (optional)

VII. Contact point

World Bank

Contact: Rifat Hasan
Title: Health Specialist
Tel: 458-7813
Email: rhasan@worldbank.org

Borrower/Client/Recipient

Name: The Republic of Gambia
Contact: Kebba Touray
Title: Minister of Finance and Economic Affairs
Tel: 2204227636
Email: kstouray04@mofea.gov.gm

Implementing Agencies

Name: National Nutrition Agency (NaNA)
Contact: Modou C. Phall
Title: Executive director
Tel: 2204498851
Email: modoucheyassinphall@yahoo.com

VIII. For more information contact:

The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500
Web: <http://www.worldbank.org/infoshop>