INTEGRATED SAFEGUARDS DATA SHEET
ADDITIONAL FINANCING

Report No.: ISDSA12195

Date ISDS Prepared/Updated: 02-Mar-2015

Date ISDS Approved/Disclosed: 12-Mar-2015

I. BASIC INFORMATION

1. Basic Project Data

Country:	Gambia, The	**Project ID:**	P154007
		Parent Project ID:	P143650
Project Name:	GM Maternal and Child Nutrition and Health Results Project (P154007)		
Parent Project Name:	Maternal and Child Nutrition and Health Results Project (P143650)		
Task Team Leader(s):	Rifat Hasan		
Estimated Appraisal Date:	02-Mar-2015	**Estimated Board Date:**	24-Apr-2015
Managing Unit:	GHNDR	**Lending Instrument:**	Investment Project Financing
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%)		
Is this project processed under OP 8.50 (Emergency Recovery) or OP 8.00 (Rapid Response to Crises and Emergencies)?	No		

Financing (In USD Million)			
Total Project Cost:	5.00	Total Bank Financing:	5.00
Financing Gap:	0.00		

Financing Source	**Amount**
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	5.00
Total	5.00

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

2. Project Development Objective(s)

A. Original 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.

B. Current Project Development Objectives – Parent

C. Proposed Project Development Objectives – Additional Financing (AF)

3. Project Description

Project Description

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 summary of components is as follows:

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 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 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 RHT, RAD, RBF Committee, and NaNA

The project design is as follows:

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).

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 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.

COMPONENT 2 – Delivery of Community Nutrition and PHC Services (Total US$6.33 million, including: US$2.30 million AF; US$1.85 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) PHC scale-up extended to NBR-E and LRR in support of the current MOHSW strategy; and
(c) 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 RHTs. 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.

Ebola Preparedness and Control: In the earlier restructuring of this project, US$0.50 million was reallocated to support implementation of immediate actions in the Ebola Response Plan. 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 through the restructuring. The activities are being supported by

WHO through a Memorandum of Understanding (MOU) for technical assistance. The MOU was signed on February 5, 2015. The AF will add another 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). While the restructuring was focused on immediate actions, 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 beefed up 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 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.

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 (described in greater detail in Annex 2).

Activities in Components 1 and 2 (specifically PHC and BFCI scale up) are aimed primarily at bridging the critical gap between communities and the services they need. In the current community RBF scheme, in order for a community to be contracted, it must have both PHC and BFCI structures in place. 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 Commi ttee and the Regional Health Teams. 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.

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

The project is being implemented in selected Regions of the Recipient's Territory. The selection of Regions is based on their relative performance on the key nutrition and health outcomes as well as food security indicators.

5. Environmental and Social Safeguards Specialists

6. Safeguard Policies	Triggered?	Explanation (Optional)
Environmental	Yes	New activities implemented would not modify the

Assessment OP/BP 4.01		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 nationally validated Health Care Waste Management Plan (HCWMP).
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/ BP 4.10	No	
Involuntary Resettlement OP/BP 4.12	No	
Safety of Dams OP/BP 4.37	No	
Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/BP 7.60	No	

II. Key Safeguard Policy Issues and Their Management

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
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 new food security activities refer to small-scale, household- and community-based interventions that do not trigger OP4.01 on environmental assessment. The implementation of 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. Since the original project was approved, the Government has also prepared HCWM Standard Operating Procedures that are acceptable to the Bank. The Plan and Policy have been disclosed in-country and at the InfoShop. The proposed changes 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.
2. Describe any potential indirect and/or long term impacts due to anticipated future activities

in the project area:
N.A.
3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
N.A.
4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
The project design incorporates the safe and responsible handling and disposal of medical waste through several measures. Additionally, the quality verification tool, a supervision checklist is administered on a quarterly basis, includes verification of medical waste measures by the facility. Indicators of medical waste handling are therefore being monitored in every facility on a regular basis. Poor performance on the facility quality tool score impacts the level of payment a facility service provider will receive, so facilities that perform better on waste management practices receive higher payments. This acts as an incentive to health workers to adopt good waste management practices and ensure staff adheres to the guidelines. The project management team and the Regional Project Implementation Committee play an important role in monitoring this aspect of the program. The World Bank safeguard specialist on the team provides additional guidance when required. The Health Care Waste Management Plan (HCWMP) has been revised, updated and disclosed. The HCWMP was publicly disclosed in country on January 30, 2014 and in the Infoshop on January 22, 2014 under the original project. The HCWMP and newly developed HCWM Standard Operating Procedures have also been disclosed for the AF both in-country (February 24, 2015) and in the Info-Shop (March 2, 2015). Implementation of the HCWMP was discussed and agreed with the client and will be closely monitored during project supervision. New activities implemented would not modify the safeguard arrangements of the original Project, which had triggered the health care waste safeguard and is being adequately mitigated by the HCWMP. The implementation of the proposed changes are not expected to increase the production of medical wastes beyond the original project which are adequately covered by the HCWMP. Thus, the proposed changes are not expected to have any significant or irreversible negative environmental or social impacts. In fact, the activities would have positive environmental and social impacts by supporting and strengthening communities and the health system.
5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
The institutions to be involved in the implementation of this project, i.e., the Ministry of Health and Social Welfare (including the Regional Health Teams and Health Facilities) and WHO, have the capacity to deal with the rather manageable medical waste expected from the facilities to be supported under the project.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	24-Feb-2015
Date of submission to InfoShop	02-Mar-2015
For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	////

"In country" Disclosure	
Gambia, The	24-Feb-2015
Comments:	
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/ Audit/or EMP.	
If in-country disclosure of any of the above documents is not expected, please explain why:	

C. Compliance Monitoring Indicators at the Corporate Level

OP/BP/GP 4.01 - Environment Assessment	
Does the project require a stand-alone EA (including EMP) report?	Yes [ ] No [ ] NA [×]
The World Bank Policy on Disclosure of Information	
Have relevant safeguard policies documents been sent to the World Bank's Infoshop?	Yes [×] No [ ] NA [ ]
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?	Yes [×] No [ ] NA [ ]
All Safeguard Policies	
Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have costs related to safeguard policy measures been included in the project cost?	Yes [×] No [ ] NA [ ]
Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?	Yes [×] No [ ] NA [ ]
Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?	Yes [×] No [ ] NA [ ]

III. APPROVALS

Task Team Leader(s):	Name: Rifat Hasan	
Approved By		
Safeguards Advisor:	Name:	Date:
Practice Manager/ Manager:	Name:	Date: