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Report No: PAD2133

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED SECOND ADDITIONAL GRANT

IN THE AMOUNT OF SDR 3.2 MILLION
(US$4.3 MILLION EQUIVALENT)

AND A

PROPOSED SECOND ADDITIONAL CREDIT

IN THE AMOUNT OF SDR 2.4 MILLION
(US$3.2 MILLION EQUIVALENT)

TO THE

REPUBLIC OF THE GAMBIA

FOR A

MATERNAL AND CHILD NUTRITION AND HEALTH RESULTS PROJECT

December 16, 2016

Health, Nutrition & Population
AFRICA

CURRENCY EQUIVALENTS

(Exchange Rate Effective October 30, 2016)

Currency Unit	=	Gambian Dalasi (GMD)
GMD 42.85	=	US$1
US$1	=	SDR 0.72788150

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
AF2	Second Additional Financing
AfDB	African Development Bank
ANC	Antenatal Care
APR	Annual Program Review
BFCI	Baby Friendly Community Initiative
CBG	Central Bank of the Gambia
CCT	Conditional Cash Transfer
CERC	Contingent Emergency Response Component
CPPR	Country Portfolio Performance Review
CRR	Central River Region
DCD	Department of Community Development
EU	European Union
EVD	Ebola Virus Disease
FA	Financing Agreement
FM	Financial Management
FNS	Food and Nutrition Security
GAVI	The Vaccine Alliance
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB and Malaria
GHE	Government Health Expenditures
GIFMIS	Gambian Integrated Financial Management System
GMD	Gambian Dalasi
GNI	Gross National Income
GoTG	Government of The Gambia
GP	Global Practice
HCWMP	Health Care Waste Management Plan
HMIS	Health Management Information System
HNP	Health, Nutrition and Population
HRITF	Health Results Innovation Trust Fund
IDA	International Development Association
IMAM	Integrated Management of Acute Malnutrition
IMR	Infant Mortality Rate

JPS	Joint Partnership Strategy
LRR	Lower River Region
M&E	Monitoring and Evaluation
MAM	Moderate Acute Malnutrition
MBB	Marginal Budgeting for Bottlenecks
MCNHRP	Maternal and Child Nutrition and Health Results Project
MDG	Millennium Development Goal
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
OoP	Out of Pocket
PAGE	Program for Accelerated Growth and Employment
PBF	Performance-based Financing
PDO	Project Development Objective
PHC	Primary Health Care
PIC	Project Implementation Committee
PLR	Performance and Learning Review
RAD	Regional Agriculture Directorate
RBF	Results-based Financing
RHD	Regional Health Directorate
RHT	Regional Health Team
RTF	Regional Task Force
SAM	Severe Acute Malnutrition
SBCC	Social and Behavior Change Communication
SDG	Sustainable Development Goal
SDR	Special Drawing Rights
SOE	State Owned Enterprises
SOP	Standard Operating Procedures
TCTR	Total Costs / Transfer Ratio
UCT	Unconditional Cash Transfer
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
URR	Upper River Region
U5MR	Under-five Mortality Rate
VDC	Village Development Committee
VSG	Village Support Group
WBG	World Bank Group
WFP	United Nations World Food Program
WHO	World Health Organization

Regional Vice President:	Makhtar Diop
Country Director:	Louise J. Cord
Country Representative:	Remi Kini
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Task Team Leader:	Rifat A. Hasan

THE GAMBIA
MATERNAL AND CHILD NUTRITION AND HEALTH RESULTS PROJECT

CONTENTS

ADDITIONAL FINANCING DATA SHEET

Gambia, The

AF Maternal and Child Nutrition and Health Results Project (P159693)

AFRICA

GHN07

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:	P159693	Additional Financing Type (from AUS):	Restructuring, Scale Up
Regional Vice President:	Makhtar Diop	Proposed EA Category:	B - Partial Assessment
Country Director:	Louise J. Cord	Expected Effectiveness Date:	30-Apr-2017
Senior Global Practice Director:	Timothy Grant Evans	Expected Closing Date:	31-Jul-2021
Practice Manager/Manager:	Trina S. Haque / Gaston Sorgho	Report No:	PAD2133
Team Leader(s):	Rifat A. Hasan		

Borrower				
Organization Name	Contact	Title	Telephone	Email
The Republic of The Gambia	Abdou Kolley	Minister of Finance	2204227636	abdoukolley@hotmail.com

Project Financing Data - Parent (Maternal and Child Nutrition and Health Results Project-P143650) (in USD Million)

Key Dates

Project	Ln/Cr/TF	Status	Approval Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P143650	IDA-56230	Effective	24-Apr-2015	04-Jun-2015	30-Nov-2015	31-Jul-2019	31-Jul-2019
P143650	IDA-D0500	Effective	24-Apr-2015	04-Jun-2015	30-Nov-2015	31-Jul-2019	31-Jul-2019
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	% Disbursed
P143650	IDA-56230	Effective	USD	2.48	2.48	0.00	0.00	2.52	
P143650	IDA-D0500	Effective	USD	2.52	2.52	0.00	0.77	1.68	30.61
P143650	IDA-H9230	Effective	USD	3.68	3.68	0.00	2.46	0.87	66.83
P143650	TF-16640	Effective	USD	5.00	5.00	0.00	2.40	2.60	47.92

Project Financing Data - Additional Financing AF Maternal and Child Nutrition and Health Results Project (P159693)(in USD Million)

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

Total Project Cost:	7.50	Total Bank Financing:	7.50
Financing Gap:	0.00		

Financing Source – Additional Financing (AF)	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	3.20
IDA Grant	4.30
Total	7.50

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)	Senior Health Specialist	Maternal and Reproductive Health, Demography	GHN06
Mamata Tiendrebeogo	Procurement Specialist (ADM Responsible)	Senior Procurement Specialist	Procurement	GGO01
Ngor Sene	Financial Management Specialist	Financial Management Specialist	Financial Management	GGO26
Amba Denise Sangara	Team Member	Program Assistant	Administrative Support	GHN07

Felix Ukeh	Safeguards Specialist	Consultant	Environmental Safeguards	GEN05
Frank Anthony Fariello	Counsel	Lead Counsel	Legal	LEGAM
Maiada Mahmoud Abdel Fattah Kassem	Team Member	Finance Officer	Finance	WFALA
Menno Mulder-Sibanda	Team Member	Sr Nutrition Spec.	Nutrition	GHN13
Michael Sexton	Team Member	Health Specialist	Health	GHN07
Ndeye Magatte Fatim Seck	Team Member	Procurement Analyst	Procurement	GGO07
Ronald Upenyu Mutasa	Team Member	Senior Health Specialist	Health, Results-Based Financing	GHN01
Upulee Iresha Dasanayake	Safeguards Specialist	Consultant	Social Safeguards	AFCSN
Yassin Saine Njie	Team Member	Program Assistant	Administrative Support	AFMGM

Extended Team

Name	Title	Location

Locations

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

Additional Financing AF Maternal and Child Nutrition and Health Results Project (P159693)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

I. Introduction

1. **This project paper seeks the approval of the Executive Directors to provide a second additional financing (AF2) in an amount of SDR 5.5 Million (US$7.5 million equivalent) to the Republic of The Gambia for the Maternal and Child Nutrition and Health Results Project (MCNHRP) (P143650/H9230-GM, D0500-GM, 56230-GM, TF016640).** The proposed Second Additional Financing (AF2) is an International Development Association (IDA) Grant (US$4.3 million equivalent) and IDA Credit (US$3.2 million equivalent) that aims to mitigate effects of economic hardships on health, nutrition and food security through the introduction of new activities as part of project restructuring and scaled-up activities to enhance the project's impact and development effectiveness of a well-performing project. This will include: (i) unconditional cash transfers to vulnerable households; (ii) quality of care improvements; (iii) expansion of community food and nutrition security interventions; and (iv) expansion of social and behavior change communication activities under Components 1, 2 and 3 of the Project. At present, there is insufficient funding for these activities. The closing date for the original and previous additional financing (AF1) will be extended to share the same closing date with the new loan and grant.

2. **The proposed AF2 would support efforts to mitigate short-term economic poverty by supporting vulnerable families to access health and nutrition services and protecting basic service delivery in an effort to continue progress toward the overall objectives of the project.** Late and erratic rains in 2014 have increased the risk of food and nutrition insecurity. In addition, the macro-economic situation has experienced some very difficult years, greatly limiting public resources available for social sectors. There is evidence of growing food and nutrition insecurity, rising inflation, risk of further devaluation of the dalasi, and impending spending cuts, holding back and undermining achievements under the project on both the demand and supply sides of service delivery and utilization.

3. **The 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 PDO level indicator has been reformulated to reflect the core indicators, and five new intermediate outcome indicators have been added to reflect the additional activities aimed at enhancing household food and nutrition security and health service utilization, in particular related to the unconditional cash transfers. In addition, targets for existing indicators have been updated to reflect scale-up of some of the activities.

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 Sustainable Development Goals (SDGs) 2, 3 and 5 and the Health, Nutrition and Population Global Practice goal of ending preventable deaths and disability through Universal Health Coverage.**[1] 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 (Mirvis and Bloom 2008; Grantham-McGregor et al 2007). 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 World Bank's twin goals of eliminating extreme poverty and boosting shared prosperity.

[1] SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture; SDG 3: Ensure healthy lives and promote well-being for all at all ages; SDG 5: Achieve gender equality and empower all women and girls

5. **The MCNHRP is instrumental in accelerating a reform process initiated by United Nations Children's Fund (UNICEF) to revitalize primary health care and is coordinating with European Union (EU)/UNICEF on cash transfers.** The Project Implementation Committee (PIC) composed of the Ministry of Health and Social Welfare (MOHSW) and the National Nutrition Agency (NaNA) hold technical working meetings that are either bilateral or with multiple development partners (e.g., UNICEF, UNFPA, WHO, GFATM, and the EU) to coordinate efforts in the health sector. The project also coordinates with the EU and United Nations World Food Program (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, UNICEF and WFP are the main partners for the food security and Unconditional Crash Transfer (UCT) aspects of the project with the others (UNICEF, UNFPA, and GFATM) more involved in the health and other nutrition aspects of the project, including water, sanitation and hygiene. 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 US$7.5 million

A. Background

6. **The proposed AF2 will strengthen the development impact of the project and enhance the achievement of the project development objective (PDO).** The MCNHRP originally had two sources of financing: (i) an International Development Association (IDA) Grant of SDR 2.4 million (US$3.68 million equivalent) and (ii) a US$5.0 million grant from the Multi-Donor Trust Fund for Health Results Innovation (HRITF; TF016640) which were approved by the Executive Directors and Regional Vice President, respectively, on March 21, 2014 and April 9, 2014. Both became effective on May 20, 2014 with a closing date of July 31, 2019. Two additional sources of financing were approved on April 24, 2015 to address a food and nutrition security crisis: (i) an IDA Grant of SDR 1.8 million (US$2.53 million equivalent) and (ii) an IDA Credit of SDR 1.8 million (US$2.48 million equivalent) which became effective on November 30, 2015. The MCNHRP was also restructured on December 1, 2014 to reallocate SDR 330,000 (US$500,000 equivalent) to support the Government in its immediate efforts to prevent and control Ebola. To date, approximately 41.14 percent of total financing has been disbursed, ahead of expected disbursement rates at this stage in the project.

7. **The PDO of the MCNHRP 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 and health services include the aspects of food, health and care as per the internationally accepted conceptual framework for nutrition. In addition, the social determinants of health framework establishes the economic determinants of health outcomes, including health expenditures and share of out-of-pocket payments. The original project included three components: (i) community mobilization for social and behavior change; (ii) delivery of community nutrition and primary health care services; and (iii) capacity building for service delivery, results based management, food and nutrition security and cash transfers. The MCNHRP was restructured on December 1, 2014 to reallocate SDR 330,000 (US$500,000 equivalent) to create a fourth component [(iv) Ebola virus disease prevention and control] to support the Government in its immediate efforts on Ebola which has now been completed.

8. **The overall objective of the project is to improve health and nutrition outcomes among women and children in the least served Regions.** Progress toward achievement of the project development objective (PDO) and overall implementation progress are both rated Satisfactory.

Implementation is going well and meets expectations in terms of both disbursements and results achieved. The Annual Program Review was conducted in April-May 2016 and was very valuable to identify implementation challenges, lessons learned and adjustments for implementation going forward. The project has scaled up to all five regions, covering all health centers and hospitals in these regions as well as an increase in the number of communities being directly contracted through the community results-based financing (RBF) scheme. There is an impact evaluation associated with the project, which requires a 2-phase roll-out; thus, disbursements were expected to be slow during Phase 1 through June 2016. The project has now gone to scale which will help increase disbursements on Component 2.

9. **The World Bank received a request for the AF2 from the MCNHRP from the Government of The Gambia on June 28, 2016.** The AF2 would consolidate early achievements and mitigate risks to the PDO of economic hardships on health, nutrition and food security through: (i) unconditional cash transfers to vulnerable households; (ii) quality of care improvements; (iii) expansion of community food and nutrition security interventions; and (iv) expansion of social and behavior change communication activities. Thus, the AF2 would support both a scale-up of activities to enhance development impact and additional project activities to mitigate economic hardships on vulnerable households.

10. **The request is consistent with the World 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" dated January 2011, revised July 2014 (Procurement Guidelines) and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011, revised July 2014 (Consultant guidelines).

B. Country Context

11. **The key long-term development challenges facing The Gambia are related to its undiversified economy, small internal market, limited access to resources, limited skills necessary to build effective institutions, high population growth, limited private sector job creation, and high rate of outmigration.** Resilience to external shocks (such as volatile weather conditions and the effects of climate change) needs to be strengthened through (a) diversification of the economy and an improved private sector investment climate; (b) effective civil service reform and improved public management capacity geared toward enhanced service delivery and conditions to support long-term growth and employment; and (c) improved transparency and accountability in public affairs and citizen participation. The Gambia is a small economy that relies primarily on tourism, agriculture, and remittance inflows and is vulnerable to external shocks, as illustrated most recently by the Ebola virus disease crisis and the poor harvest in 2014. From 2010 through 2014, real gross domestic product (GDP) growth averaged 2.7 percent and shrank by an average of 0.5 percent in per capita terms, in part reflecting a severe drought that contributed to a 4.3 percent contraction in GDP in 2011.

12. **Fiscal strains have mounted substantially in recent years, largely due to fiscal slippages and poor performance of State Owned Enterprises (SOEs) that have led to a significant build-up of public sector debt.** The fiscal deficit averaged 11 percent as a share of GDP from 2013 through 2015, contributing to a rise in public sector debt to 108 percent of GDP in 2015, from 83.3 percent in 2013. Heavy reliance on costly domestic markets has contributed to rising debt. Interest payments increased from 25 percent of revenues in 2013 to 40 percent in 2015, and are projected to reach nearly 50 percent in 2016. Contingent liabilities that reached 5 percent of GDP in 2014 are also a contributing factor.

13. **Exchange rate policies that sharply overvalued the Gambian dalasi have also contributed to financial strains and balance-of-payment imbalances.** The Central Bank of the Gambia (CBG) official foreign reserves have declined significantly, with the periodic imposition of currency controls since 2013 and overvaluation against the U.S. dollar as high as 30 percent over pre-peg, market-determined rates. This has posed challenges to private sector investment and strained the capacity of the authorities to service public sector debt.

14. **The last World Bank Group (WBG) country strategy for The Gambia was the second Joint Partnership Strategy (JPS-2) for the fiscal years 2013 to 2016 (report number 72140-GM), which was a joint document of the WBG and the African Development Bank (AfDB).** The JPS-2 was designed to respond to three main development challenges of The Gambia, namely, (i) restoring growth and macroeconomic stability; (ii) improving service delivery; and (iii) improving transparency and accountability in public financial management and public procurement. Implementation, however, has faced new challenges. The Gambia has been re-classified as a fragile state during the JPS-2 period – since 2014 – and the country's economic performance has been adversely affected by external shocks and policy slippages. This has affected the social sectors, and thus, improving human capital and social services, in particular access to and quality of health services and nutrition and food security interventions, remain among the strategic priorities for poverty reduction. A Performance and Learning Review (PLR) has been prepared and has reviewed the WBG performance under this strategy. The PLR is expected to propose an extension of support while a Systematic Country Diagnostic and Country Partnership Framework are developed. This PLR sets out proposed WBG support to the Gambian authorities for FY17. The review focused on the poorest sections of the population, who are most affected by current macroeconomic strains and fiscal slippages and who would likely face the largest impacts in the event the situation deteriorates further. The MCNHRP contributions to these priorities are set out in a planned PLR for The Gambia. This proposed AF2 complements other WBG-supported investment projects that impact health and nutrition, notably those in agriculture (i.e., the West Africa Agriculture Productivity Program and the Commercial Agriculture and Value Chain Management Project) and the West African Medicines Regulatory Harmonization Project. Finally, the AF2 is fully aligned with the priorities of the Government of The Gambia (GoTG) as laid out in the Program for Accelerated Growth and Employment (PAGE), 2012-2015 and PAGE II (2017-2020).

C. Sectoral Context

15. **Maternal, Reproductive, Child Health and Nutrition:** Poor maternal, reproductive, and child health and nutrition outcomes in The Gambia continue to be profound and pervasive problems with some indicators actually deteriorating over time. The Gambia ranks 170 out of 176 countries on the Mother's Index behind countries like Chad, Guinea-Bissau and Nigeria.[2] The utilization of many critical services has either stagnated or deteriorated, contributing to poor maternal and child health. The health sector, despite the achievements of the recent past, is under growing pressure due to a number of factors: high population growth, "verticalized" service delivery, insufficient financial resources, deterioration of physical infrastructure, serious shortfalls in supplies and equipment, shortage of trained health personnel, high attrition rate as well as inadequate referral system. Poverty, traditional beliefs and low awareness contribute to inappropriate health seeking behaviors, further eroding efforts to improve health outcomes.

[2] "State of the World's Mothers", 2013, Save the Children. 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 (v) Participation of women in national government

16. Malnutrition is a contributing cause of almost half of under-five mortality[3], and undernutrition is a major cause of lost human capital in the Gambian population through direct losses in productivity linked to poor physical status, indirect losses due to poor cognitive function and learning deficits, and losses resulting from increased medical costs. Poor nutrition outcomes have a multitude of causes, ranging from inappropriate and inadequate infant and young child caring and feeding practices, poor maternal health and nutrition status, poor hygiene and sanitation, high disease burden, inadequate home management of common childhood illnesses, low utilization of health services, and inadequate access to diversified and nutrient-rich foods at all times. Many of these factors interact simultaneously and become worse during the lean season when food shortages force families to change their routines often with negative consequences for child growth and nutrition (and thus the formation of human capital). In The Gambia, food shortages are seasonal. The most difficult months of the year correspond with the lean season period, which spans from May to September with the most difficult month being August. The below-average harvests of 2014 provided food for the household for a much shorter period than usual. As the cycles of lower than average rainfall, shorter crop seasons and ensuing food and nutrition insecurity become increasingly frequent as a result of climate change,[4] a structural approach is needed to strengthen the community and household resilience to recurring external shocks.

17. For the reasons mentioned above, the World Bank has prioritized reproductive, maternal and child health and nutrition through three initiatives. (i) In July 2015, the Global Financing Facility for Reproductive, Maternal, Newborn, Child and Adolescent Health was launched to provide smart, scaled and sustainable financing to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths by 2030. (ii) The Power of Nutrition - a new independent fund launched on April 16, 2015 – will help millions of children reach their full potential. Backed by leading organizations from private philanthropy and international development, the partnership aims to unlock one billion dollars to tackle child undernutrition in some of the world's poorest countries. (iii) In addition, in April 2016 during the Spring Meetings, a new priority initiative was announced to promote overall child development and rid the world of stunting as it perpetuates poverty, increases economic disparity and slows economic growth. This was followed by a "Human Capital Summit: Investing in the Early Years for Growth and Productivity" featuring various country leaders that took place during the Annual Meetings on October 6, 2016. The Gambia finds itself at a crossroad where, after years of seeing gradual improvements in the rate of stunting, it now sees the situation deteriorate at an increasing pace. At the same time, reproductive and maternal health indicators have stagnated or deteriorated.

18. **Gender and Vulnerability:** Development of the agricultural sector over the last decades has led to a gradual erosion of local food economies (largely managed by women) which are at the heart of ensuring household food security. A recent study on the role of women in production, consumption and reproduction in The Gambia highlights the fact that most women have no control over land and other productive resources. These developments have increased the vulnerability of women and thus their children.

19. Gender norms are at the heart of maternal and child nutritional deficiencies and health outcomes. Traditional male-centered norms and values weigh heavily on women's access to productive resources and capacity to determine their well-being and that of their offspring. This starts in early adolescence and can produce harmful effects throughout different stages of the lifecycle. Therefore, the role of women as child bearers cannot be separated from that of women as providers of food security. Together they highlight a picture of conflicting demands on women's time and responsibilities and as a result high levels of vulnerability, which become worse during times of economic recession as witnessed in The Gambia.

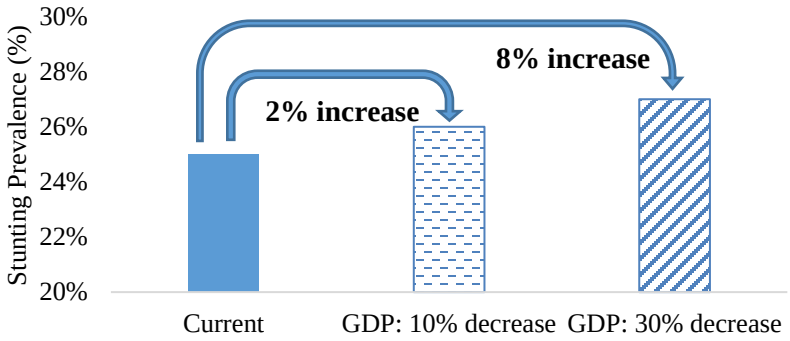
[3] Black et. Al. (2013). Maternal and child undernutrition and overweight in low-income and middle-income countries. The Lancet, Volume 382, Issue 9890, Pages 427-51.

[4] www.fews.net

20. **Macroeconomic Effect on Nutrition and Health:** Layered on challenges in the food, health and nutrition sectors, a rapidly deteriorating macroeconomic policy framework is exacerbating the situation. Policy buffers have been substantially eroded, greatly limiting public resources available for social sectors. Macroeconomic challenges, combined with the growing risk of food insecurity and already strained health and nutrition sectors, are placing a growing burden directly on households with more intense negative health and nutrition effects anticipated in the next year.

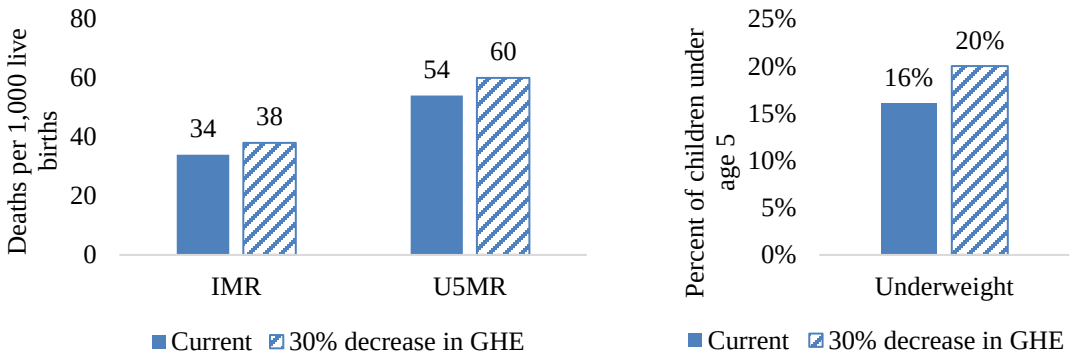
21. Two possible fiscal scenarios are expected: GDP contraction and/or hyperinflation. Both scenarios would have serious and lasting impacts on health and nutrition outcomes. Globally, there is a strong negative relationship between stunting of children under age 5 and GDP. Based on a Sub-Saharan Africa model, a contraction of the current GDP in The Gambia by 10 percent (GDP declining from US$560 to US$504) would increase the proportion of stunted children by 2 percent. If GDP were to contract further to 30 percent, stunting is estimated to increase by 8 percent (Figure 1).

Figure 1. Anticipated impact of GDP contraction on stunting prevalence



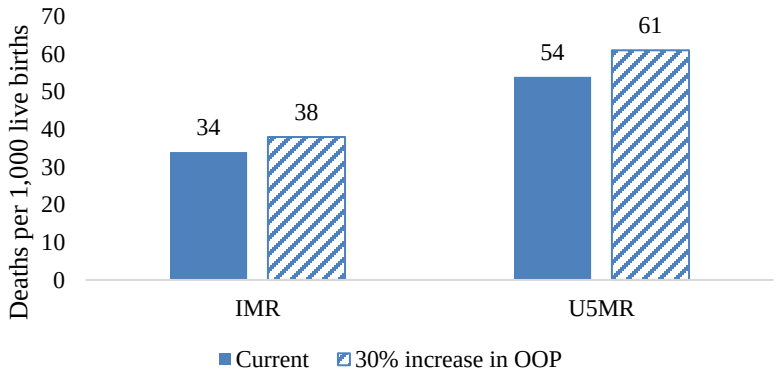
22. Another indicator of GDP contraction is a reduction in government health expenditures (GHE). Based on modeled estimates, a decrease in GHE by 30 percent would increase the percentage of underweight children from 16 percent to 20 percent. A 30 percent decrease in GHE would also result in higher mortality – Infant Mortality Rate (IMR) would increase to 38 deaths per 1,000 live births, and Under-five Mortality Rate (U5MR) would increase to 60 deaths per 1,000 live births. While child health has improved – and indeed the Gambia has surpassed its Millennium Development Goal (MDG) 4 U5MR target (57) – reduction in GHE by 30 percent would reverse these gains (Figure 2).

Figure 2. Impact of decreased government health expenditures (GHE) on infant and under-5 mortality and underweight prevalence



23. Hyperinflation would also negatively impact health and nutrition outcomes as well as health seeking behaviors. Hyperinflation means that prices increase – effectively, this means that at household level, out of pocket (OoP) expenditures would increase even to purchase the same level of healthcare. Currently, OoP expenditures as a share of total health expenditures is 17 percent and as a share of private health expenditures is 55 percent. Projections indicate that a 30 percent increase in the OoP expenditure share[5] would result in IMR increasing from 34 to 38 deaths per 1,000 live births. U5MR is projected to increase from 54 to 61 deaths per 1,000 live births (Figure 3).

Figure 3. Impact of increased OoP share of health expenditures on infant and under-5 mortality



24. Given the level of OoP payments currently needed to access care (for example, for medicines and transport), in a scenario where prices increase drastically, people will not be able to afford preventive and primary healthcare. This will delay timely healthcare seeking, not only putting people at risk for more severe illnesses but also mortality. If and when people do seek care in cases of emergencies or on a delayed timeframe which makes treatment more expensive, households will be at risk of financial shocks, further exacerbating ill health and poverty.

25. Increase in prices will affect the poorest households the most. Due to financial hardships, care-seeking behaviors will be most muted for the most vulnerable and poorest given higher barriers to access. Thus, health and nutrition outcomes will deteriorate especially for the poorest households, further increasing inequity. Thus, most of the population, especially those not formally employed, remains vulnerable to financial risk from health care expenditures.

26. In addition to health and nutrition outcomes, macroeconomic effects on the health system are anticipated to be substantial and lasting. Contraction of GDP and reductions in GHE would lead to weakened stewardship of the health sector (thereby weakening oversight over public resources) and inefficiencies in the delivery of services. Recent gains in the Health Management Information System would be quickly lost, putting the health sector in a situation of weak monitoring of results and accountability. The medicines and supplies situation in health facilities is of particular concern. The supply of medicines and supplies has already started to suffer with high levels of stock-outs. In the anticipated fiscal scenarios, international lines of credit would be jeopardized, further putting at risk the procurement and delivery of the essential package of maternal and child health and nutrition supplies and medicines (e.g. oxytocin to reduce the risk of maternal death, and antibiotics).

27. Poor performance of the health sector will have a negative effect on community mobilization for health and nutrition action as well. Not being able to treat illnesses will degrade trust and confidence

[5] Modeled estimates hold total health expenditures constant.

between health care providers and community structures. This could impact negatively on exclusive breastfeeding, complementary feeding and overall community level health and nutrition behaviors, further deteriorating outcomes and setting back achieved gains. The motivation of community health and nutrition workers will likely reduce in these conditions. There is some flexibility with food as there are some coping strategies – fewer meals per day, trade-off on quality of food items – but these will have an impact on nutrition and health.

D. Opportunities for Successful Implementation

28. **The MCNHRP has been implementing a set of complementary activities to address health, nutrition and food security: RBF approach to improve health and nutrition at health facility and community levels combined with social and behavior change communication (SBCC) and food and nutrition security (FNS) activities.** An annual program review (APR) conducted in May 2016 indicated promising results from the implementation of the RBF and SBCC activities in the first phase of the project. Utilization of health and nutrition services, including family planning, antenatal care and post-natal care have increased. Staff motivation, job satisfaction and innovation appear to have improved in intervention 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 use RBF payments to help women – for example, some communities have been saving multiple rounds of RBF payments to purchase a donkey cart or motorized tricycles to transport women to health facilities for safe delivery. As a result, the linkages between health facilities and communities have been strengthened through the combination of demand- and supply-side initiatives. In addition, quality of care has improved through the administration of quality checklists. However, more work remains on quality of care. Initial improvements have focused on structural quality. The next challenge is transitioning to a greater focus on clinical quality of service delivery. Lessons also indicate an opportunity to intensify implementation of the SBCC activities to increase demand for services and adoption of healthy behaviors to maximize project impact.

29. **Using existing community-level structures – Village Support Groups (VSGs) and Village Development Committees (VDCs) – has enabled the delivery of community RBF and SBCC activities as well as targeted food and nutrition security interventions.** This experience with targeting of vulnerable households (based on poverty and gender criteria developed from results of a multi-sectoral gender study and household data) has laid the ground to use the same targeting method for the cash transfers.

30. **These promising results point to opportunities to: (i) build on the experience of improvements in service delivery to address remaining bottlenecks in quality of care; and (ii) build on the experience of working with VSGs and VDCs to broaden the scope of SBCC and community action for improved health, nutrition, and household food security to include vulnerabilities and economic constraints.**

III. Proposed Changes

Summary of Proposed Changes

The AF2 will mitigate effects of economic hardships on health, nutrition and food security through the introduction of new activities as part of project restructuring and scaled-up activities to enhance the impact and development effectiveness of a well-performing project. The AF2 will specifically:

a. Expand in the reach, scope and intensity of the Social and Behavior Change Communication

(SBCC) Strategy to: (i) include institutional communication on objectives and selection criteria of unconditional cash transfers; and (ii) include social and behavior change messages on adolescent health and nutrition, early childhood care and early stimulation under Component 1;

b. Scale-up food and nutrition security (FNS) activities to additional wards in the current Project Regions under Component 2;
c. Introduce unconditional cash transfers (UCTs) complementary to the FNS and results-based financing interventions under Component 2;
d. Support further improvements in quality of care, including mechanisms to improve (i) supply chain management; (ii) procurement of short-term supply of essential medicines; (iii) management of moderate acute malnutrition; and (iv) reproductive health under Component 2;
e. Increase scale and intensity of ongoing capacity building for service delivery, RBF, FNS and UCTs under Component 3; and
f. Introduce a Contingent Emergency Response Component (CERC) in the project that permits rapid restructuring of projects to meet crises and emergency needs.

As part of the restructuring, the disbursement categories of the original financing and previous additional financing (AF1) will be restructured. The original financing will be restructured to expand scope to include the original and AF1 regions (i.e. five regions: NBR-W, URR, CRR of original & NBR-E, LRR of AF1) and create a new Category 7 for the CERC. The AF1 will be restructured to (i) combine Categories (1a) and (1b) into new Category (1); (ii) combine Categories (2a) and (2b) into new Category (2); and (iii) combine Categories (3a), (3b) and (4) into new Category (3). The AF2 will then add more financing to restructured Category (3) and create new Category (6) for UCTs. Finally, the AF2 will create a new Category (7) for the CERC.

The PDO remains unchanged on the understanding that nutrition and health services include the aspects of food, health and care as per the internationally accepted conceptual framework for nutrition. In addition, the social determinants of health framework establishes the economic determinants of health outcomes, including health expenditures and share of out-of-pocket payments.

The current project is being implemented in five health regions, with an expectation of reaching approximately 235,700 children under five and 241,800 women aged 15-49 years, yielding a total of 477,500 direct beneficiaries. The proposed AF2 will reach these individuals with the additional food security interventions, the new UCTs and better quality of care and SBCC activities. The AF2 will reach an additional 49,000 new direct beneficiaries (42,000 children under five and 7,000 women aged 15-49 years) with expanded FNS activities and the new UCTs. All 526,500 beneficiaries will benefit from quality of care improvements and expansion of SBCC activities.

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 [ ] No [X]
Change in Loan Closing Date(s)	Yes [X] No [ ]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [ ] No [X]
Reallocation between Disbursement Categories	Yes [X] No [ ]
Change in Disbursement Estimates	Yes [ ] No [X]
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 [X] No [ ]
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:

One PDO level indicator has been reformulated to reflect HNP core indicators, and five additional intermediate outcome indicators have been added as follows: (i) one on citizen engagement and feedback to reflect community involvement and ownership of the project; (ii) one on quality of care; and (iii) three on the unconditional cash transfers being a new activity that is introduced under the Additional Financing.

In addition, targets for existing indicators have been updated to reflect scale-up of some of the activities.

Compliance

Covenants - Additional Financing (AF Maternal and Child Nutrition and Health Results Project - P159693)

Source of Funds	Finance Agreement Reference	Description of Covenants	Date Due	Recurrent	Frequency	Action
IDA	Schedule 2. Section II. B (5)	The Recipient shall recruit, not later than four (4) months after the Effective Date, a senior finance assistant and a principal accountant in accordance with Section III of Schedule 2 of this Agreement under terms of reference satisfactory to the Association, to carry out such functions as set forth in the Project Operations Manual.	30-Aug-2017	☐		New

Conditions

Source Of Fund	Name	Type
IDA	Withdrawal condition Schedule 2, Section IV, B	Disbursement

Description of Condition

Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made (b) for payments under Category 3 until the Association has provided prior written approval for such withdrawal, once the proceeds of the First Additional Financing allocated to Category 3 in the table set forth in Schedule 2, Section IV.A.2 of the First Additional Financing Agreement have been fully disbursed.

Source Of Fund	Name	Type
IDA	Withdrawal condition Schedule 2, Section IV, B	Disbursement

Description of Condition

Notwithstanding the provisions of Part A of this Section, no withdrawal shall be made (c) for Emergency Expenditures under Category 7, unless and until the Association is satisfied, and notified the Recipient of its satisfaction, that all of the following conditions have been met in respect of said expenditures as set in (i), (ii),(iii), (iv).

Source Of Fund	Name	Type
IDA	Withdrawal condition Schedule 2, Section IV, B	Disbursement

Description of Condition

The Recipient shall, for each Category: (a) withdraw the proceeds of the Grant allocated to such Category, for 100% of Eligible Expenditures, from the Grant Account until such proceeds are fully disbursed; (b) thereafter, withdraw the proceeds of the Credit allocated to such Category, for 100% of Eligible Expenditures, from the Credit Account.

Risk

Risk Category	Rating (H, S, M, L)
1. Political and Governance	High
2. Macroeconomic	High
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 (AF Maternal and Child Nutrition and Health Results Project - P159693)

Source of Funds	Proposed Additional Financing Loan Closing Date
International Development Association (IDA)	31-Jul-2021

Loan Closing Date(s) - Parent (Maternal and Child Nutrition and Health Results Project - P143650)

Explanation:

To align with the new sources of funding and restructuring of project activities, the original and new loans and grants will share the same closing date.

Ln/Cr/TF	Status	Original Closing Date	Current Closing Date	Proposed Closing Date	Previous Closing Date(s)
IDA-56230	Effective	31-Jul-2019	31-Jul-2019	31-Jul-2021	31-Jul-2019
IDA-D0500	Effective	31-Jul-2019	31-Jul-2019	31-Jul-2021	31-Jul-2019
IDA-H9230	Effective	31-Jul-2019	31-Jul-2019	31-Jul-2021	
TF-16640	Effective	31-Jul-2019	31-Jul-2019	31-Jul-2021	31-Jul-2019

Allocations - Additional Financing (AF Maternal and Child Nutrition and Health Results Project - P159693)

Source of Fund	Currency	Category of Expenditure	Allocation	Disbursement %(Type Total)
			Proposed	Proposed
IDA	XDR	GDS, WK, NCS, CS, TR, G OP under Parts A.3, B.2 and C of the Project (Category 3)	4.00	100.00
IDA	XDR	Unconditional Cash Transfers under Part B.4 (Category 6)	1.60	100.00
IDA	XDR	Emergency Expenditures under Part E of the Project (Category 7)	0.00	100.00
		Total:	5.60	

Reallocation between Disbursement Categories

Explanation:

As part of the restructuring, the disbursement categories of the original financing and previous additional financing (AF1) will be restructured. The original financing will be restructured to expand scope to include the original and AF1 regions (i.e. five regions: NBR-W, URR, CRR of original & NBR-E, LRR of AF1) and create a new Category 7 for the CERC. The AF1 will be restructured to (i) combine Categories (1a) and (1b) into new Category (1); (ii) combine Categories (2a) and (2b) into new Category (2); and (iii) combine Categories (3a), (3b) and (4) into new Category (3). The AF2 will then add more financing to restructured Category (3) and create new Category (6) for UCTs. Finally, the AF2 will create a new Category (7) for the CERC.

Ln/Cr/TF	Currency	Current Category of Expenditure	Allocation		Disbursement %(Type Total)	
			Current	Proposed	Current	Proposed
TF-16640	USD	Condit cash Transfer parts A.1, A.2 (Category 1)	980,000.00	980,000.00	58.00	58.00
TF-16640		PBF Grants part B.1 (Category 2)	1,110,000.00	1,110,000.00	58.00	58.00
TF-16640		GDS,WK,NCS,CS,TRG OP prt A.3,B.2,C (Category 3)	2,910,000.00	2,910,000.00	58.00	58.00
TF-16640		Designated Account	0.00	0.00	0.00	0.00
TF-16640		Designated Account	0.00	0.00	0.00	0.00
		Total:	5,000,000.00	5,000,000.00		

IDA-56230	SDR	Cond Cash transf A1,A2 NBRW,CRR,URR (Category 1a – closed)	0.00	0.00	100.00	100.00
IDA-56230		Cond Cash transf A1,A2,NBR-E,LRR (Category 1b – closed))	423,000.00	0.00	100.00	100.00
IDA-56230		PBF B1,NBR-W,CRR,URR (Category 2a – closed)	0.00	0.00	100.00	100.00
IDA-56230		PBF,B1,NBR-E,LRR (Category 2b – closed))	299,000.00	0.00	100.00	100.00
IDA-56230		GD,WK,NCS,CS,TG,OC, B2 NBRW,CRR,URR (Category 3a – closed)	0.00	0.00	100.00	100.00
IDA-56230		GD,WK,NCS,CS,TG,OC, B2 NBR-E,LRR (Category 3b – closed)	212,000.00	0.00	100.00	100.00
IDA-56230		GD,WK,NCS,CS,TG,OC, A3 AND C (Category 4 – closed)	778,000.00	0.00	100.00	100.00
IDA-56230		GD,WK,NCS,CS,TG,OC,PART B3 (Category 5)	88,000.00	88,000.00	100.00	100.00
IDA-56230		Designated Account	0.00	0.00	0.00	0.00
IDA-56230		Designated Account	0.00	0.00	0.00	0.00
IDA-56230		Conditional Cash transfers under Parts A1 and A2 of the Project (Category 1)	0.00	423,000.00	0.00	100.00
IDA-56230		PBF Grants under Part B.1 of the Project (Category 2)	0.00	299,000.00	0.00	100.00
IDA-56230		GD, WK, NCS, CS, TG, OC under Parts A3, B2 and C of the Project (Category 3)	0.00	990,000.00	0.00	100.00
IDA-56230		Emergency Expenditures under Part E of the Project (Category 7)	0.00	0.00	0.00	100.00
		Total:	1,800,000.00	1,800,000.00		

IDA-D0500	SDR	Cond Cash transf A1,A2 NBRW,CRR,URR (Category 1a – closed)	0.00	0.00	100.00	100.00
IDA-D0500		Cond Cash transf A1,A2,NBR-E,LRR (Category 1b – closed)	431,000.00	2,000.00	100.00	100.00
IDA-D0500		PBF B1,NBR-W,CRR,URR (Category 2a – closed)	0.00	0.00	100.00	100.00
IDA-D0500		PBF,B1,NBR-E,LRR (Category 2b – closed)	305,000.00	10,000.00	100.00	100.00
IDA-D0500		GD,WK,NCS,CS,TG,OC, B2 NBRW,CRR,URR (Category 3a – closed)	0.00	0.00	100.00	100.00
IDA-D0500		GD,WK,NCS,CS,TG,OC, B2 NBR-E,LRR (Category 3b – closed)	216,000.00	20,000.00	100.00	100.00
IDA-D0500		GD,WK,NCS,CS,TG,OC, A3 AND C (Category 4 – closed)	758,000.00	0.00	100.00	100.00
IDA-D0500		GD,WK,NCS,CS,TG,OC,PART B3 (Category 5)	90,000.00	90,000.00	100.00	100.00
IDA-D0500		Designated Account	0.00	0.00	0.00	0.00
IDA-D0500		Designated Account	0.00	0.00	0.00	0.00
IDA-D0500		Conditional Cash transfers under Parts A1 and A2 of the Project (Category 1)	0.00	429,000.00	0.00	100.00
IDA-D0500		PBF Grants under Part B.1 of the Project (Category 2)	0.00	295,000.00	0.00	100.00
IDA-D0500		GD, WK, NCS, CS, TG, OC under Parts A3, B2 and C of the Project (Category 3)	0.00	954,000.00	0.00	100.00
IDA-D0500		Emergency Expenditures under Part E of the Project (Category 7)	0.00	0.00	0.00	100.00

		Total:	1,800,000.00	1,800,000.00		
IDA-H9230	SDR	Condit cash Transfer parts A.1, A.2 (Category 1)	500,000.00	500,000.00	42.00	42.00
IDA-H9230		PBF Grants part B.1 (Category 2)	500,000.00	500,000.00	42.00	42.00
IDA-H9230		GDS,WK,NCS,CS,TRG OP prt A.3,B.2,C (Category 3)	1,070,000.00	1,070,000.00	42.00	42.00
IDA-H9230		GDS,NCS,CS,TRG OP prt D (Category 4)	330,000.00	330,000.00	100.00	100.00
IDA-H9230		Designated Account	0.00	0.00	0.00	0.00
IDA-H9230		Designated Account	0.00	0.00	0.00	0.00
IDA-H9230		UN Advances	0.00	0.00	0.00	0.00
IDA-H9230		UN Advances	0.00	0.00	0.00	0.00
IDA-H9230		Emergency Expenditures under Part E of the Project (Category 7)	0.00	0.00	0.00	100.00
		Total:	2,400,000.00	2,400,000.00		

Components

Change to Components and Cost

Explanation:

The AF2 will support unconditional cash transfers as an additional activity within the project and further support improvements to quality of care, expansion of food and nutrition security activities, and expansion of social and behavior change communication activities in the MCNHRP (P143650). The MCNHRP is currently being implemented in the five health regions of the country: North Bank Region West (NBR-West), North Bank Region East (NBR-East), Central River Region (CRR), Upper River Region (URR) and Lower River Region (LRR), reaching approximately 477,500 direct beneficiaries. With the new activities and expansion under the AF2, a total of 526,500 direct beneficiaries are estimated. The total 526,500 beneficiaries will benefit from quality of care improvements and expansion of SBCC activities. Overall, the components will be as indicated below with the changes with the AF2 italicized:

Component 1: Community Mobilization for Social and Behavior Change

- Conditional cash transfers to communities and support groups
- Conditional cash transfer to individuals for timely antenatal care (ANC)
- Social and behavior change communication (SBCC) *to include messaging on vulnerabilities and unconditional cash transfers, adolescent health and nutrition, early childhood care and early stimulation as well as increased implementation intensity*

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
- *Unconditional cash transfers*
- *Quality of care*

Component 3: Capacity Building for Service Delivery, Results-Based Management, Food and Nutrition Security and Cash Transfers

- Capacity building
- Monitoring and Evaluation (M&E), operational research and verification
- Coordination and program management at all levels
- Performance contracts with RHD, *RTF*, DCD, RBF Committee, and NaNA

Component 4: Ebola Virus Disease Preparedness and Control

- Social mobilization
- Case management

Component 5: Contingent Emergency Response

COMPONENT 1 – Community Mobilization for Social and Behavior Change (Total US$5.15 million, including: US$1.00 million AF2; 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) and improved food and nutrition security; (ii) CCTs to individual women to increase utilization of timely antenatal care (ANC); 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 changes include strengthening of institutional communication with the introduction of messages around vulnerability and objectives of the unconditional cash transfers (UCTs) in the SBCC and Community Mobilization Strategies. In addition, SBCC messages will be expanded to include adolescent health and nutrition, early childhood care and early stimulation. Furthermore, as the economic situation deteriorates, it is becoming increasingly evident that additional SBCC efforts will be needed than originally envisaged, and the AF will support quality messaging and tool development and strengthening of implementation intensity.

COMPONENT 2 – Delivery of Community Nutrition and PHC Services (Total US$11.53 million, including: US$5.70 million AF2; 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 as well as local food and nutrition security 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 (37 facilities in five health regions); (ii) startup support for effective service delivery, including the implementation of selected health care waste management measures; (iii) health system strengthening for infectious disease preparedness and control (specifically for strengthening the data management and reporting system); (iv)

Primary Health Care (PHC) scale-up in support of the MOHSW strategy; and (v) food security-enhanced BFCI across all five health regions. The proposed changes to this component are:

(a) Scaling-up food security-enhanced BFCI;
(b) Introduction of unconditional cash transfers; and
(c) Quality of care improvements.

Scaling-up Food Security-Enhanced BFCI: The most vulnerable people to food and nutrition insecurity shocks as well as economic degradation 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. The MCNHRP is currently using a targeting approach to reach the most vulnerable households with FNS inputs, including backyard gardens, poultry and small ruminants. In addition, communities are also supported for longer term resilience to establish child food banks and plant fruit trees. In an effort to reach more households with the FNS inputs to enhance household resilience against recent economic downturns, the AF2 will support the scale-up of the FNS interventions to additional villages in the existing project regions.

Vulnerable households are identified using a combination of geographical, categorical and community targeting approaches. Based on health, nutrition and food security indicators, the food-security enhanced BFCI is being implemented in the five project regions: North Bank West, North Bank East, Upper River, Central River and Lower River Regions. Nutrition surveillance data is used to select wards with the poorest nutrition indicators. Community-based targeting is used to identify the eligible group, pregnant women and women with children under five, living in the most vulnerable households. Village selection committees established at community level will use a combination of categorical and vulnerability criteria to select beneficiaries. The beneficiary lists will be publicly validated through community assemblies. The regional task forces will conduct verifications on a randomly selected sample for inclusion and exclusion errors.

Introduction of Unconditional Cash Transfers (UCTs): In line with the vulnerability assessment above, the immediate beneficiaries of the UCTs will be women and children in targeted communities, and the UCTs will be complementary to the existing FNS interventions, the SBCC efforts, and RBF mechanisms under the project. The UCTs will be provided under the AF2 to households that currently receive FNS inputs to bridge the gap between the receipt of FNS inputs and until they start bearing fruit. Thus, a common targeting approach will be used to identify vulnerable households for the proposed UCTs and the existing FNS activities. Unconditional transfers will address short-term household economic constraints. It has been widely documented that cash transfers programs directly affect household consumption and food consumption (De Groot 2015). In the Gambian highly volatile economic context, UCTs – in combination with the other complementary activities – will protect the purchasing power and the level of expenditures, especially on health and nutrition in households with pregnant women and young children. In combination with strong and effective SBCC messages, the UCTs will contribute to the overall project outcome to improve nutrition and health status of pregnant women and children under five. The long-term effect of the health and nutrition outcomes may result in improved cognitive outcomes and performance in school and, later, increased productivity and lifetime earnings. The AF2 will also support capacity building for management and coordination associated with the expansion of FNS activities and introduction of the UCTs.

The value of the transfer was calculated considering households' food expenditures and the gap for them to access a minimum food basket. The value of the food basket of a household of 8 members is estimated at 5,200 GMD/month using national market prices, while the food expenditures range from 1,645 GMD/month to 2,892 GMD/month during the leaning season (out of pocket survey 2014). The food expenditure gap that a household of 8 members needs to cover in order to access the minimum food basket is equivalent to 2,308 GMD/month after the harvest and 3,555 GMD/month during the leaning period. The value of the transfers

will be set at a value between 15 percent and 30 percent of the household food expenditure gap during the leaning time. This will represent a transfer value comprised between 500 and 1,000 GMD/month. This range represents a trade-off between a larger transfer value that would likely result in stronger household outcomes but would reach fewer beneficiaries with smaller transfers, risking not to attain the intended impact. The transfers will help beneficiaries to meet immediate primary needs over a period of 12 months. This support, coupled with the other interventions, will contribute to the attainment of the development objectives of the project. UCTs will be delivered to beneficiaries using local microfinance institutions. This has proven to be an efficient delivery mechanism in previous cash transfer programs in The Gambia. The proposed cash transfer intervention does not tie the transfers to any conditionality. The complementarity of the project activities will facilitate that beneficiaries and communities be engaged in a range of activities that encourage SBCC, promote health seeking behaviors and food security.

Addressing Bottlenecks in Quality of Care: A number of bottlenecks related to quality of care have been identified during project implementation, and the AF2 will support specific interventions to address these issues. One of the key challenges is the inadequate supply of medicines to health facilities. Based on the recommendations of a procurement and supply chain assessment that has been conducted, the AF2 will support mechanisms using RBF principles to improve supply chain management and procure a short-term supply of essential medicines. Management of moderate acute malnutrition (MAM) has not received the same attention as the management of severe acute malnutrition (SAM). The AF2 will additionally support the development and dissemination of guidelines for the management of MAM as part of the Integrated Management of Acute Malnutrition (IMAM), including more active and frequent monitoring and intensive management at community level. Finally, the AF2 will support improvements in quality of reproductive healthcare provision (e.g. quality of family planning counseling, antenatal care provision, skilled delivery), including in-service clinical training on these services.

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 and Community Mobilization Strategies 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 FNS scale-up and introduction of UCTs in Component 2 will enable communities to address vulnerabilities (including related to gender) and improve access to health and nutrition services and food. Building on the ongoing activities and existing implementation arrangements, the AF2 allows expanding the scope of the project at the community level to scale-up support for FNS and introduce UCTs.

COMPONENT 3 – Capacity Building for Service Delivery, Results-Based Management, Food and Nutrition Security and Cash Transfers (Total US$4.00 million, including: US$0.80 million AF2; US$0.90 million AF;US$0.92 million IDA; US$1.38 million HRITF): In the original project, performance contracts were signed with NaNA, MOHSW RBF Committee, and Regional Health Directorates (RHDs). With the additional UCT activities that will be implemented at community level, the AF2 will also support capacity building, monitoring and oversight for cash transfers, including with Regional Task Forces (RTFs).

The AF2 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 FNS activities, expansion of scope to now include UCTs, intensification of quality of care, and implementation intensity of SBCC activities.

COMPONENT 4 – Ebola Virus Disease 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) were supported. The activities were supported by WHO through a Memorandum of Understanding (MoU) for technical assistance. The MOU was signed on February 5, 2015 and activities completed by June 30, 2016. No additional financing will be allocated for Component 4.

COMPONENT 5 – Contingent Emergency Response (CERC) (Total financing: US$0 million IDA): A CERC will be included under the project in accordance with Operational Policy (OP) 10.00 paragraphs 12 and 13, for projects in Situations of Urgent Need of Assistance or Capacity Constraints. This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

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	4.15	5.15	Revised
Delivery of community nutrition and primary health care services	Delivery of community nutrition and primary health care services	5.83	11.53	Revised
Capacity building for service delivery and results based financing	Capacity building for service delivery, results-based financing, food and nutrition security and cash transfers	3.20	4.00	Revised
Ebola preparedness and control	Ebola preparedness and control	0.50	0.50	No Change
	Contingent Emergency Response	0.00	0.00	New
	Total:	13.68	21.18	

Other Change(s)

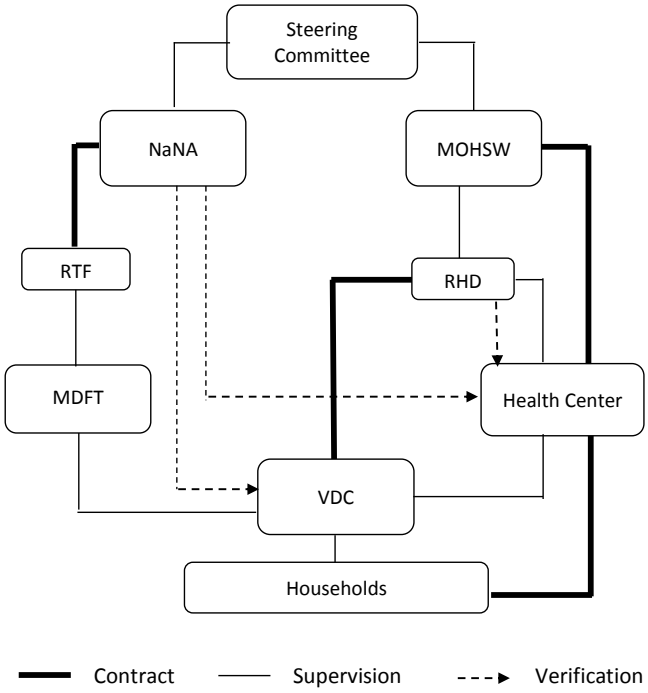
Implementing Agency Name	Type	Action
National Nutrition Agency (NaNA)	Implementing Agency	No Change

Change in Institutional Arrangements

Explanation:

The institutional arrangements for the AF2 will undergo only 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. The adjustments under the AF2 are: (i) as part of Component 3, NaNA will sign performance contracts with the multi-sectoral Regional Task Force (instead of the Regional Agricultural Department – RAD) to liaise on the food security interventions and cash transfers; and (ii) a payment provider (microfinance institution) will be identified to distribute the cash transfers at community level. NaNA will provide capacity building to the RTFs 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.



Change in Financial Management

Explanation:

Financial management (FM) staff: with the AF2, which include new activities such as unconditional cash transfers, the FM requirements of the project will become complex, and more support of the finance team for the operationalization of those activities will be required. Therefore the FM team (an FM Specialist and an Accountant, supported by five Regional FM Assistants) will be overloaded. Premised on these facts, an additional Accountant and finance staff who are experienced in the implementation of World Bank funded projects will be recruited to reinforce the FM staff. The proposed staff to be recruited to support these additional activities are a Principal Accountant and a Senior Finance Assistant. They should be recruited no later than four months after effectiveness date.

Flow of funds: For the AF2, separate new Designated Accounts (DAs) will be opened for each source of financing (grant and credit). Both will use transaction-based disbursements (i.e. Statement of Expenses).

Change in Procurement

Explanation:

NaNA will continue to be responsible for all procurement activities. The Procurement Unit is currently staffed with one Procurement Officer who is responsible for all procurement activities of the project as well as of NaNA. The overall risk for procurement is rated moderate in PRAMS. Given the already heavy workload, the Procurement Officer is overstretched and will face challenges in correctly handling additional activities of the AF2. To ensure effective procurement in light of the current PRAMS risk rating and heavy workload, a qualified Procurement Assistant will be hired to support the Procurement Officer. This will help ease the burden of work, decrease procurement delays and further improve quality of procurement activities.

The procurement for the proposed AF2 will be carried out in accordance with the World Bank's relevant Guideline. These are "Guidelines: Procurement of Goods, Works and Non-Consulting Services under IBRD Loans and IDA Credit & Grants by World Bank Borrowers" dated January 2011, revised July 2014 (Procurement Guidelines) and "Guidelines: Selection and Employment of Consultants under IBRD loans and IDA credits & Grants by World Bank Borrowers" dated January 2011, revised July 2014 (Consultant Guidelines).

Change in Implementation Schedule

Explanation:

With the US$7.5 million additional financing, new activities are being added while some existing activities will be scaled up with respect to both geographic and technical scope. As a result, the closing date for the project will be extended until July 31, 2021, resulting in a modified implementation schedule.

Appraisal Summary

Economic and Financial Analysis

Explanation:

The AF2 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: UNCONDITIONAL CASH TRANSFERS

Due to the limited data available, the analysis focuses on specific design features that affect the cost and performance of the cash transfer intervention and therefore can be considered critical drivers of cost-effectiveness: (i) targeting efficiency; (ii) transfer levels; and (iii) conditionality.

The proposed cash transfer intervention will target 9,200 eligible households (40 percent of the population) within the geographically selected villages. One of the questions that have been debated during the design phase was whether the proposed cash transfer intervention should adopt universal coverage or target only the most vulnerable households. A method proposed by Samson (2012) was used to compare the net costs and benefits of the two approaches. The savings of targeting only the eligible group living under the poverty line would be of around US$0.6 million, i.e. 26.8 percent of the total budget. These gains should be discounted of potential inclusion and exclusion errors occurring when targeting. In order to reduce these errors and make targeting more effective (e.g. social cohesion, no domination by elites), the design will build upon the experience that the MCNHRP project has gained through the targeting of the food and nutrition security activities.

The transfer has been set to a value that should be enough to help beneficiary households meet their nutritional needs. A transfer value of 700 GMD/month (US$17/month) is expected to cover 20 per cent of the food expenditure gap during the leaning period. This compares fairly well with other programs that are quoted as internationally sound standards (Garcia and Moore 2012). The size of the transfer also matters in terms of potential impact on children's nutritional status. A number of studies, based on CCT experience in Latin America, have shown that when the size of the transfer is larger, the effect of the program on children's nutritional status is also greater. Evidence from the Transfer Project across Sub-Saharan Africa suggests that transfers that are at least 20 per cent of baseline household expenditures are more likely to have impacts on outcomes of interest (Davis and Handa 2015). Based on this evidence, the proposed transfer represents a trade-off between a larger transfer value that would likely result in stronger household outcomes but would reach fewer beneficiaries and a smaller transfer that would risk not to have the intended impact.

Another major driver of cost-effectiveness concerns conditionality. The main question is whether the benefits of conditionality, if any, justify the cost of implementing it. There is no conclusive evidence on whether the positive benefits of CCTs result from conditions placed on the grant or simply from the fact that households have more money (usually combined with SBCC) with which to buy food and go to health centers (Bailey 2012). Evidence from several African countries has also shown that unconditional social grants reduce hunger among both children and adults by increasing household food expenditure and dietary diversity, and measurably improve children's height-for-age and weight-for-height indicators (Seidenfel 2014, Samson 2009). Therefore, the proposed cash transfer intervention does not introduce any conditionality, partly because of its potentially high demand in term of resources, time and costs for the program and beneficiaries. Furthermore, the complementarity of the project activities makes the potential benefits of conditionality less relevant, as beneficiaries and communities benefit from a range of activities that utilize SBCC to promote nutrition, health seeking behaviors and food security.

DEVELOPMENT IMPACT: FOOD AND NUTRITION SECURITY INTERVENTIONS

Interventions financed by the AF2 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 AF2. 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 Marginal Budgeting for Bottlenecks (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.

The delivery of better quality primary health care services and health system strengthening, 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 has been developed under the original project. 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 sanitation 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. Intensifying and expanding the SBCC messages through AF2 with respect to adolescent health and nutrition, early childhood care and early stimulation will further improve efficiency of existing implementation.

The proposed cash transfer intervention is equally or more cost-efficient than other cash transfer programs in other Sub-Saharan countries, independently of their maturity and coverage. The cost-efficiency of the cash transfer activities expressed as total costs / transfer ratio (TCTR) is 1.25, while the alpha ratio (transfer cost/ total costs) is 0.8. The alpha ratio shows that 80 per cent of the resources will be delivered directly to beneficiaries as cash transfers. The TCTR of the proposed cash transfer intervention has been compared to those of other cash transfer programs in Sub-Saharan Africa. With the exception of some social pension programs, which are highly efficient because they apply simple categorical targeting at scale, the proposed cash transfers can be considered either equally or more cost-efficient than other cash transfer programs in Sub-Saharan Africa, which were used as benchmarks. The main design features that make the proposed cash transfer intervention cost-efficient are the simple community-based targeting and the absence of conditionality that would require compliance monitoring mechanisms.

Technical Analysis

Explanation:

The proposed approach under the AF2 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 unconditional Cash Transfers (UCTs) will be complementary to the FNS interventions and the behavior change communication efforts under the project. UCTs will be targeted to the most vulnerable households. In order to identify these households, a combination of geographical, categorical and community-based targeting approaches will be used. This targeting methodology will build upon the project efforts of strengthening the local capacity to set up and manage community-based targeting for FNS activities. The value of the transfers will be set at a value between 15 percent and 30 percent of the household food expenditure gap during the leaning time. This would represent a transfer value comprised between 500 and 1,000 GMD/month. This range represents a trade-off between a larger transfer value that would likely result in stronger household outcomes but would reach fewer beneficiaries and smaller transfers that would risk not to have the intended impact. The transfers will support vulnerable households to meet immediate primary needs over a period of 12 months that, coupled with the other interventions, will contribute to the development objectives of the project.

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. The RBF approach of the MCNHRP has shown an increased uptake in maternal and child health and nutrition services (e.g. post-natal care) and improved quality of care (e.g. shift from unskilled to skilled health workers attending deliveries in health facilities).

Social Analysis

Explanation:

Women and children are particularly vulnerable to both food and nutrition insecurity and access to health services. 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's Roles in Production, Consumption and Reproduction*), women are disadvantaged economically within the household, women in better-off households fare better, and women seem to have very limited control (albeit a small amount exists) over their own land, income and other productive resources. 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.

Gender norms are at the heart of maternal and child nutritional deficiencies and health outcomes. Traditional male-centered norms and values weigh heavily on women's access to productive resources and capacity to determine their well-being and that of their offspring. This starts in early adolescence and can produce harmful effects throughout different stages of the lifecycle. Therefore, the role of women as child bearers cannot be separated from that of women as providers of food security. Together they highlight a picture of

conflicting demands on women's time and responsibilities and as a result high levels of vulnerability, which become worse during times of economic recession.
Therefore, the immediate beneficiaries will be women and children in food and nutrition insecure households and communities. Project activities contribute to addressing gender constraints. The social protection activities of the MCNHRP in providing cash transfers to women act as a timely compensation for the loss of women's income during pregnancy and support their care-taking role of children. Regarding access to health care, women face both demand-side and supply-side constraints. The demand side constraints are largely cultural, behavioral or related to mobility. The AF2 expands and intensifies SBCC activities to address such constraints. The project currently seeks to address the supply-side constraints using RBF approaches, and the AF2 will intensify this with a stronger focus on quality of care (including, for example, quality of family planning counseling). The project currently addresses demand-side constraints with a combination of SBCC and CCTs for antenatal care. The AF2 will further strengthen this with the introduction of UCTs that target vulnerable households. In these ways, the project activities strengthen primary health and nutrition care and directly improve women's access to quality care and, in turn, health outcomes.

The targeting of activities under the AF2 will further address gender constraints. The AF2 will support scaling up of FNS activities and introduction of UCTs to help households to weather financial shocks. A common targeting approach will be used to identify vulnerable households for the proposed UCTs and the existing FNS activities. Households will be identified using a combination of geographical, categorical and community targeting approaches which address the vulnerability dimensions as identified in the gender report *Women's Roles in Production, Consumption and Reproduction*. Categorical targeting will be applied, and specific gender and vulnerability criteria – based on the above report and household data – include: (i) households with pregnant women and children under five years of age; (ii) female-headed households; and (iii) households that are identified by the community as being economically vulnerable.

The existing activities and proposed changes support the World Bank Health Nutrition and Population (HNP) Global Practice's (GP's) commitment to reducing gender gaps in health and nutrition outcomes. This is essential for its aim for achieving universal health coverage, promoting better reproductive, maternal, adolescent, newborn, and child health, and harnessing the power of nutrition. A gendered lens is pivotal for ensuring that the GPs investments will achieve desired results and contribute towards the WBG's twin goals of boosting prosperity and reducing poverty. As outlined in the HNP Gender Strategy paper, the HNP GP will leverage new opportunities to ensure a gender lens in its analytical and operational work.

Environmental Analysis

Explanation:

The activities under the AF2 would not lead to an increase in medical waste generation and therefore would not modify the safeguard arrangements under the parent project. The parent project triggered the Environmental Assessment policy (OP/BP 4.01) due to the potential increase in medical waste generation, which could result from the anticipated increase in the number of health care beneficiaries in the project region. Subsequently, a nationally validated Health Care Waste Management Plan (HCWMP) was prepared, cleared and publicly disclosed in country on January 30, 2014 and at the Infoshop on January 22, 2014. In addition, since the parent project became effective on May 20, 2014, a few Standard Operating Procedures (SOPs) have been developed to accompany the HCWMP, including training of healthcare workers on the SOPs. Also 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 World Bank. The HCWMP and the HCWM Standard Operating Procedures were disclosed for the first AF both in-country (February 24, 2015) and in the Info-Shop (March 2, 2015). As part of the first AF, 13 additional mini-medical waste incinerators are being modified in accordance with the recommendations of the HCWMP and actions have been taken to recruit a technical consultant to finalize the design. This would be followed by retaining a contractor to build the incinerators to appropriate specifications.

The food security activities being implemented, which refer to small-scale, household- and community-based interventions, and the new cash transfers proposed in AF2 do not trigger OP 4.01 on environmental assessment.

The project has already contributed to improved policies and procedures for health care waste management, and the proposed changes in the AF2 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; cash transfers) would have net 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 second additional financing and disclosed on November 16, 2016.

Risk

Explanation:

The overall risk continues to be rated as substantial. he original risks remain relevant but 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 level) and macroeconomic (fiscal policies have deteriorated) have been elevated to high. Risks related to the project specifically, though, remain stable and continue to be relevant: technical design of project (multi-sectoral nature of the project, including: the introduction of a new approach to health financing through RBF, innovative design features such as demand-side and community-based incentives, cash transfers); fiduciary measures (including the need for close inter-institutional coordination with multiple government agencies involved in the implementation). Implementation arrangements remain unchanged and the implementing agencies have relevant experiences.

V. World Bank Grievance Redress

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 (P159693) – 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.

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
Revised	Children 0-6 months exclusively breastfed	☐	Percentage	Value	47.00	49.00	60.00
				Date	31-Dec-2013	31-Dec-2015	31-Jul-2021
				Comment			
Revised	Births (deliveries) attended by skilled health personnel (number)	☐	Number	Value	8885.00	15315.00	23000.00
				Date	31-Dec-2013	30-Sep-2016	31-Jul-2021
				Comment			
Revised	Children 6-23 months consuming at least four out of six food groups	☐	Percentage	Value	19.00		35.00
				Date	31-Dec-2013		31-Jul-2021
				Comment			
Revised	Women using modern methods of family planning	☐	Number	Value	12925.00	14963.00	20000.00
				Date	31-Dec-2013	30-Sep-2016	31-Jul-2021
				Comment			
Revised	Direct project beneficiaries		Number	Value	0.00	201622.00	1400000.00

		☒		Date	28-Feb-2014	31-Dec-2015	31-Jul-2021
				Comment			
No Change	Female beneficiaries	☒	Percentage Sub Type Supplemental	Value	70.00	83.00	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 complication management	☐	Number	Value	0.00	3165.00	12000.00
				Date	28-Feb-2014	29-Apr-2016	31-Jul-2021
				Comment			
Revised	Hand washing stations/points established	☐	Number	Value	0.00	2049.00	6000.00
				Date	28-Feb-2014	29-Apr-2016	31-Jul-2021
				Comment			
Revised	Community registers updated quarterly	☐	Number	Value	341.00	634.00	560.00
				Date	31-Jan-2014	30-Sep-2016	31-Jul-2021
				Comment			
Revised	Pregnant/lactating women, adolescent girls and/or children under age five-reached by basic nutrition services (number)	☒	Number	Value	90000.00	186380.00	593000.00
				Date	31-Jan-2014	29-Apr-2016	31-Jul-2021
				Comment			
Revised	Children between the age of 6 and 59 months receiving Vitamin A supplementation (number)	☒	Number Sub Type Breakdown	Value	70000.00	83806.00	475000.00
				Date	31-Jan-2014	30-Sep-2016	31-Jul-2021
				Comment			
Revised	Pregnant women receiving iron and folic acid (IFA) supplements (number)	☒	Number Sub Type Breakdown	Value	9000.00	59929.00	18000.00
				Date	31-Jan-2014	30-Sep-2016	31-Jul-2021
				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	39252.00	95000.00
				Date	31-Jan-2014	30-Sep-2016	31-Jul-2021
				Comment			
Revised	Children under age five treated for moderate or severe acute malnutrition (number)	☒	Number Sub Type Breakdown	Value	200.00	2060.00	5000.00
				Date	31-Jan-2014	30-Sep-2016	31-Jul-2021
				Comment			
Revised	Communities implementing BFCI activities	☐	Number	Value	633.00	633.00	1100.00
				Date	11-Mar-2015	30-Sep-2016	31-Jul-2021
				Comment			
Revised	Children 12-59 dewormed in the preceding year	☐	Number	Value	6461.00	53067.00	46000.00
				Date	31-Dec-2013	30-Sep-2016	31-Jul-2021
				Comment			
Revised	Pregnant women coming for ANC in the first trimester in the preceding year	☐	Number	Value	2342.00	9277.00	12000.00
				Date	31-Dec-2013	30-Sep-2016	31-Jul-2021
				Comment			
Revised	Post-partum mothers supplemented with VAS in the preceding year	☐	Number	Value	22200.00	21130.00	26000.00
				Date	31-Dec-2013	29-Apr-2016	31-Jul-2021
				Comment			
Revised	Vulnerable households supported in participating in gardening, keeping ruminants, or keeping poultry	☐	Number	Value	0.00	0.00	5000.00
				Date	26-Feb-2015	31-Dec-2015	31-Jul-2021
				Comment			
Revised	Communities supported in establishing child food banks	☐	Number	Value	0.00	0.00	250.00
				Date	09-Feb-2015	31-Dec-2015	31-Jul-2021
				Comment			

Revised	Health workers (including central and regional level managers) trained on RBF management	☐	Number	Value	38.00	332.00	200.00
				Date	31-Jan-2014	29-Apr-2016	31-Jul-2021
				Comment			
No Change	RBF adopted in the revised health financing policy	☐	Yes/No	Value	No	No	Yes
				Date	31-Dec-2013	29-Apr-2016	31-Jul-2019
				Comment			
Revised	Health personnel receiving training (number)	☒	Number	Value	0.00	810.00	1200.00
				Date	28-Feb-2014	29-Apr-2016	31-Jul-2021
				Comment			
No Change	Health personnel trained on Ebola prevention and management	☐	Number	Value	0.00	305.00	100.00
				Date	11-Nov-2014	30-Jun-2016	31-Jul-2019
				Comment			
New	Health facilities receiving Client Tracer and Satisfaction Survey feedback at least 3 times during the calendar year	☐	Percentage	Value	0.00		70.00
				Date	15-Nov-2016		31-Jul-2021
				Comment			
New	Health facilities scoring at least 75% on the Quality Checklist	☐	Percentage	Value	0.00		100.00
				Date	15-Nov-2016		31-Jul-2021
				Comment			
New	Selected recipients who meet the targeting criteria	☐	Percentage	Value	0.00		80.00
				Date	15-Nov-2016		31-Jul-2021
				Comment			
New	Selected recipients who receive all cash transfers according to the payment plan	☐	Percentage	Value	0.00		80.00
				Date	15-Nov-2016		31-Jul-2021
				Comment			
New	Recipients of UCT		Number	Value	0.00		5000.00

		☐		Date	15-Nov-2016		31-Jul-2021
				Comment			

Annex 2: Map of The Gambia