COMBINED PROJECT INFORMATION DOCUMENTS / INTEGRATED SAFEGUARDS DATA SHEET (PID/ISDS)
ADDITIONAL FINANCING

Report No.: PIDISDSA20309

Date Prepared/Updated: 04-Nov-2016

I. BASIC INFORMATION

A. Basic Project Data

Country:	Gambia, The	**Project ID:**	P159693
		Parent Project ID (if any):	P143650
Project Name:	AF Maternal and Child Nutrition and Health Results Project (P159693)		
Parent Project Name:	Maternal and Child Nutrition and Health Results Project (P143650)		
Region:	AFRICA		
Estimated Appraisal Date:	07-Nov-2016	**Estimated Board Date:**	30-Mar-2017
Practice Area (Lead):	Health, Nutrition & Population	**Lending Instrument:**	Investment Project Financing
Borrower(s):	The Republic of The Gambia		
Implementing Agency:	National Nutrition Agency (NaNA)		

Financing (in USD Million)

Financing Source	Amount
BORROWER/RECIPIENT	0.00
International Development Association (IDA)	7.50
Total Project Cost	7.50

Environmental Category:	
Appraisal Review Decision (from Decision Note):	
Other Decision:	Environmental Category: B - Partial Assessment since this second Additional Financing (AF2) is an extension of a parent project with Category B status.
Is this a Repeater project?	No

B. Introduction and Context

Country Context

The key long-term development challenges facing The Gambia are related to its undiversified economy, small internal market, limited access to resources, lack of skills necessary to build effective institutions, high population growth, lack of 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 West Africa 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.

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.

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. The controls have constrained the availability of foreign exchange, discouraged private investment, and strained the capacity of the authorities to service public sector debt. The lifting of currency controls since January 2016 and restoration of market-determined flexible exchange rates, should facilitate a rebuilding of foreign reserves over time. However, while greater exchange rate flexibility is evident in the 15 percent dalasi depreciation against the US-dollar for the year, as of end-September 2016, possible moral suasion and administrative controls could be encumbering the degree of adjustment of the exchange rate and the pace of official reserve accumulation.

The last World Bank Group country strategy for The Gambia was the second Joint Partnership Strategy (JPS) for the fiscal years 2013 to 2016 (report number 72140-GM), which was a joint document of the World Bank Group and the African Development Bank (AfDB). A Performance and Learning Review (PRL) is under preparation, which reviews the World Bank Group performance under this strategy and will propose an extension of it while a Systematic Country Diagnostic and Country Partnership Framework are developed. This Performance and Learning Review will set out World Bank Group support to the Gambian authorities in calendar 2016. The review is expected to focus 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. This proposed AF is part of that approach.

Sectoral and institutional Context

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 (Annex 1). The Gambia ranks 170 out of 176 countries on the Mother►(s Index behind countries like Chad, Guinea-Bissau and Nigeria. 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 rate, increasing morbidity and mortality, ►(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.

Malnutrition is a contributing cause of almost half of under-five mortality , 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, a structural approach is needed to strengthen the community and household resilience to recurring external shocks.

It►(s for the reasons mentioned above that the World Bank has prioritized reproductive, maternal and child health and nutrition through two initiatives. 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. In addition, in April 2016 during the Spring Meetings, a new priority initiative was launched to rid the world of stunting as it perpetuates poverty, increases economic disparity and slows economic growth. 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.

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. The same study shows that women have little or no control over their body and their health either.

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 decide her well-being and that of her offspring. This st arts 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.

MACROECONOMIC EFFECT ON HEALTH AND NUTRITION: 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. 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% (GDP declining from US$560 to US$504) would increase the proportion of stunted children by 2%. If GDP were to contract further to 30%, stunting is estimated to increase by 8%. Another indicator of GDP contraction is a reduction in government health expenditures (GHE). Based on modeled estimates, a decrease in GHE by 30% would increase the percentage of underweight children from 16% to 20%. A 30% decrease in GHE would also result in higher mortality ►(IMR would increase to 38 deaths per 1,000 live births, and U5MR would increase to 60 deaths per 1,000 live births. While child health has improved ►(and indeed the Gambia has surpassed its MDG 4 U5MR target (57) ►(reduction in GHE by 30% would reverse these gains.

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 as a share of total health expenditures is 17% and as a share of private health expenditures is 55%. Projections indicate that a 30% increase in the OOP expenditure share 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. Given the level of out of pocket payments currently needed to access care (for example, for drugs and transport), in a scenario where prices increase drastically, people will not only 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. 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.

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 drugs and supplies situation in health facilities is of particular concern. The supply of drugs 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 drugs (e.g. oxytocin for maternal mortality, antibiotics).

Poor performance of the health sector will have a negative effect on community nutrition efforts as well. Not being able to treat for illness will degrade trust and confidence in community nutrition 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 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.

C. Proposed Development Objective(s)

Original Project Development Objective(s) - Parent

A. Proposed Development Objective

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

Key Results

D. Project Description

The AF2 will support new unconditional cash transfers, 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.

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

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

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

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

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; 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 the introduction of messages around vulnerability in the SBCC Strategy and objectives of the unconditional cash transfers (UCTs) in the Community Mobilization Strategy. 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) Scale-up of food security-enhanced BFCI; and
(b) Unconditional cash transfers.

Scale-up of 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, which are being 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. Categorical targeting is then applied to specifically identify the eligible group: pregnant women and women with children under the age of five years. Community targeting will identify the most vulnerable households based on vulnerability (e.g. households with less than two meals consumed per day) and categorical criteria (women headed households, household size). The geographic targeting (up to the selection of villages) will be done by the Project Implementation Committee at national level while the categorical and community targeting will be done by a selection committee at village level. (Identification of vulnerable households described in greater detail in Annex 2.) 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.

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. As a result, 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.

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. By 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 and Results-Based Financing (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 the PIC, NaNA, MOHSW RBF Committee, Regional Health Directorates (RHDs) and the Regional Agriculture Directorates (RAD). 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.

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 drugs 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 drugs. Management of moderate acute malnutrition (MAM) has been insufficient given the scale of needs on the ground. The AF2 will additionally support the management of MAM, including more active and frequent monitoring at community level and te development of guidelines for 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.

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 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 Name

Community mobilization for social and behavior change

Comments (optional)

Component Name

Delivery of community nutrition and primary health care services

Comments (optional)

Component Name

Capacity building for service delivery, results-based financing, food and nutrition security and cash transfers

Comments (optional)

Component Name

Ebola preparedness and control

Comments (optional)

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

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

F. Environmental and Social Safeguards Specialists

Felix Ukeh (GEN05)

Upulee Iresha Dasanayake (AFCSN)

II. Implementation

Institutional and Implementation Arrangements

The implementation arrangements for the AF2 will undergo minor changes from those for the current project. At the central level, the arrangements remain the same with the NaNA and the MOHSW as the implementing agencies of the project. The MOHSW and NaNA implement the project jointly through the Project Implementation Committee (PIC) composed of NaNA and MOHSW staff. Both MOHSW and NaNA work through the RHD to oversee community mobilization and service

delivery. For Component 1, the Regional Health Directorates (RHDs) continue as the purchaser of community results through: (i) RBF contracts with the Village Development Committee (VDC) for maternal and child nutrition and health results, including food and nutrition security results, in the five target Regions; and (ii) conditional cash transfers (CCT) to individual women to increase utilization of timely antenatal care. For Component 2, the MOHSW RBF Committee continues as the purchaser of health service delivery results through performance-based grant to health centers for the delivery of a predefined package of maternal and child health and nutrition services at primary and referral health care facilities. The accompanying measures aimed at promoting behavioral changes and increasing demand to improve household practices related to health and nutrition through SBCC (Component 1), the provision of startup support for effective service delivery, including the implementation of selected health care waste management measures to RBF contracted facilities as well as the food security enhanced BFCI and PHC scale up to all and the majority of communities respectively (Component 2) will be implemented through the existing arrangement using input-based financing. NaNA will provide capacity building to the 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.

The (minor) changes in implementation arrangements emanating from the proposed changes in activities 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.

III. Safeguard Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The proposed activities under this AF2 would not modify the safeguard arrangements, or trigger additional Safeguard Policy. The Environmental Assessment Policy (OP/BP 4.01) was triggered by the parent project and as a result, a nationally validated Health Care Waste Management Plan (HCWMP) was prepared, cleared and disclosed in country and at the Bank➢(s Infoshop. The HCWMP Plan will be re-disclosed with the AF2.
Natural Habitats OP/BP 4.04	No	
Forests OP/BP 4.36	No	
Pest Management OP 4.09	No	
Physical Cultural Resources OP/BP 4.11	No	
Indigenous Peoples OP/BP 4.10	No	
Involuntary Resettlement OP/ BP 4.12	No	
Safety of Dams OP/BP 4.37	No	

Projects on International Waterways OP/BP 7.50	No	
Projects in Disputed Areas OP/ BP 7.60	No	

IV. Key Safeguard Policy Issues and Their Management

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

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 health care beneficiaries. 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 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 OP4.01 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 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.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

N.A.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.

N.A.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

The project design incorporates the safe and responsible handling and disposal of medical waste through several measures. Additionally, the quality verification tool, a supervision checklist is administered on a quarterly basis, includes verification of medical waste measures by the facility. Indicators of medical waste handling are therefore being monitored in every facility on a regular basis. Poor performance on the facility quality tool score impacts the level of payment a facility service provider will receive, so facilities that perform better on waste management practices receive higher payments. This acts as an incentive to health workers to adopt good waste management practices and ensure staff adheres to the guidelines. The project management team and the Regional Project Implementation Committee play an important role in monitoring this aspect of the program. The World Bank safeguard specialist on the team provides additional guidance when required.

he HCWMP was publicly disclosed in country on January 30, 2014 and in the Infoshop on January 22, 2014 under the original project. In addition, since the project became effective on May 20, 2014, Standard Operating Procedures (SOPs) have been developed to accompany the HCWMP, a training done with health workers on the SOPs, and a Health Care Waste Management Policy has been developed and adopted by the MOHSW, all of which have been found to be acceptable by the Bank. Furthermore, the HCWMP and the HCWM Standard Operating Procedures were disclosed for the previous AF both in-country (February 24, 2015) and in the Info-Shop (March 2, 2015). Implementation of the HCWMP was discussed and agreed with the client and will be closely monitored during project supervision.

New activities implemented would not modify the safeguard arrangements of the original Project, which had triggered the health care waste safeguard and is being adequately mitigated by the nationally validated HHCWMP. The implementation of the proposed changes are not expected to increase the production of medical wastes beyond the original project which are adequately covered by the HCWMP.

The HCWMP prepared under the parent project incorporates safe and responsible handling and disposal of medical waste through several measures. Additionally, a quality verification tool and supervision checklist are being administered on a quarterly basis, including verification of medical waste measures by facility. Indicators of medical waste handling are also being monitored in every facility on a regular basis and the responsible agencies, including healthcare practitioners have acquired the necessary capacity to implement the HCWMP.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The institutions to be involved in the implementation of this project, i.e., the Ministry of Health and Social Welfare (including the Regional Health Directorates and Health Facilities), have the capacity to deal with the rather manageable medical waste expected from the facilities to be supported under the project. Nothing new is being triggered with the proposed changes in this second Additional Financing.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other	
Date of receipt by the Bank	20-Jan-2014
Date of submission to InfoShop	22-Jan-2014

For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors	
"In country" Disclosure	
Gambia, The	30-Jan-2014
Comments:	
If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/ Audit/or EMP.	
If in-country disclosure of any of the above documents is not expected, please explain why:	

C. Compliance Monitoring Indicators at the Corporate Level

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

V. Contact point

World Bank

Contact: Rifat Hasan
Title: Senior Health Specialist

Borrower/Client/Recipient

Name: The Republic of The Gambia
Contact: Abdou Kolley
Title: Minister of Finance
Email: abdoukolley@hotmail.com

Implementing Agencies

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

VI. For more information contact:

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

VII. Approval

Task Team Leader(s):	Name: Rifat Hasan	
Approved By		
Safeguards Advisor:	Name: Maman-Sani Issa (SA)	Date: 06-Nov-2016
Practice Manager/ Manager:	Name: Trina S. Haque (PMGR)	Date: 07-Nov-2016
Country Director:	Name: R. Gregory Toulmin (CD)	Date: 15-Nov-2016