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Report No: PAD4675

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT PAPER

ON A

PROPOSED ADDITIONAL GRANT

IN THE AMOUNT OF SDR 35.5 MILLION
(US$50.0 MILLION EQUIVALENT)

TO THE

REPUBLIC OF THE GAMBIA

FOR THE

ESSENTIAL HEALTH SERVICES STRENGTHENING PROJECT

October 29, 2021

Health, Nutrition and Population Global Practice
Western and Central Africa Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective September 30, 2021)

Currency Unit =	Gambian Dalasi (GMD)
GMD 51.62 =	US$1
SDR 0.7098 =	US$1

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
AWPB	Annual Work Plan and Budget
CBA	Cost-Benefit Analysis
CERC	Contingent Emergency Response Component
COVID-19	Coronavirus Disease 2019
CPF	Country Partnership Framework
CRVS	Civil Registration and Vital Statistics
DALYs	Disability Adjusted Life Years
DHIS2	District Health Information Software 2
DHS	Demographic and Health Survey
DPI	Directorate of Planning and Information
E&S	Environmental and Social
EHCP	Essential Healthcare Package
ESCP	Environmental and Social Commitment Plan
ESIA	Environmental and Social Impact Assessment
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
FM	Financial Management
FY	Fiscal Year
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHG	Greenhouse Gas
GLF	Government Local Fund
GoTG	Government of The Gambia
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HCI	Human Capital Index
HCW	Healthcare Waste
HMIS	Health Management Information System
IFR	Interim Financial Report
IRR	Internal Rate of Return

ISR	Implementation Status and Results Report
M&E	Monitoring and Evaluation
MCNHRP	Maternal and Child Nutrition and Health Results Project
MICS	Multiple Indicator Cluster Survey
MoFEA	Ministry of Finance and Economic Affairs
MoH	Ministry of Health
NAS	National HIV/AIDS Secretariat
NCD	Noncommunicable Disease
NEA	National Environmental Authority
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NPV	Net Present Value
NSC	National Steering Committee
PAD	Project Appraisal Document
PAP	Project-affected Person
PCU	Projects Coordination Unit
PDO	Project Development Objective
PER	Public Expenditure Review
PHC	Primary Health Care
PIC	Project Implementation Committee
POM	Project Operations Manual
RAP	Resettlement Action Plan
RBF	Results-based Financing
RfB	Request for Bid
RSSH	Resilient and Sustainable Systems for Health
SBCC	Social and Behavior Change Communication
SDG	Sustainable Development Goal
SEA	Sexual Exploitation and Abuse
SH	Sexual Harassment
STEP	Systematic Tracking of Exchanges in Procurement
UHC	Universal Health Coverage
UN	United Nations
VHS	Village Health Service
WASH	Water, Sanitation, and Hygiene
WBG	World Bank Group
WHO	World Health Organization

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Additional Financing to The Gambia Essential Health Services Strengthening Project

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BASIC INFORMATION – PARENT (The Gambia Essential Health Services Strengthening Project - P173287)

Country	Product Line	Team Leader(s)		
Gambia, The	IBRD/IDA	Samuel Lantei Mills		
Project ID	**Financing Instrument**	**Resp CC**	**Req CC**	**Practice Area (Lead)**
P173287	Investment Project Financing	HAWH3 (9542)	AWCF1 (6550)	Health, Nutrition & Population

Implementing Agency: Ministry of Health

Is this a regionally tagged project?
No

Bank/IFC Collaboration
No

Approval Date	Closing Date	Expected Guarantee Expiration Date	Environmental and Social Risk Classification
09-Oct-2020	29-Aug-2025		Moderate

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach [MPA]	[✓] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[✓] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a Non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made disaster
[ ] Alternate Procurement Arrangements (APA)	[ ] Hands-on Expanded Implementation Support (HEIS)

Development Objective(s)

To improve quality and utilization of essential health services in The Gambia.

Ratings (from Parent ISR)

	Implementation	Latest ISR
	17-Feb-2021	27-Sep-2021
Progress towards achievement of PDO	S	S
Overall Implementation Progress (IP)	S	S
Overall ESS Performance	S	S
Overall Risk	M	M
Financial Management	S	MS
Project Management	S	S
Procurement	MS	S
Monitoring and Evaluation	S	S

BASIC INFORMATION – ADDITIONAL FINANCING (AF to The Gambia Essential Health Services Strengthening Project - P177263)

Project ID	Project Name	Additional Financing Type	Urgent Need or Capacity Constraints
P177263	AF to The Gambia Essential Health Services Strengthening Project	Restructuring, Scale Up	No
Financing instrument	Product line	Approval Date	
Investment Project Financing	IBRD/IDA	19-Nov-2021	
Projected Date of Full Disbursement	Bank/IFC Collaboration		
31-Dec-2025	No		
Is this a regionally tagged project?			

No	

Financing & Implementation Modalities

[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a Non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made disaster
[ ] Alternate Procurement Arrangements (APA)	[ ] Hands-on Expanded Implementation Support (HEIS)
[✓] Contingent Emergency Response Component (CERC)	

Disbursement Summary (from Parent ISR)

Source of Funds	Net Commitments	Total Disbursed	Remaining Balance	Disbursed
IBRD				%
IDA	30.00	3.22	27.10	11 %
Grants				%

PROJECT FINANCING DATA – ADDITIONAL FINANCING (AF to The Gambia Essential Health Services Strengthening Project - P177263)

FINANCING DATA (US$, Millions)

SUMMARY (Total Financing)

	Current Financing	Proposed Additional Financing	Total Proposed Financing
Total Project Cost	34.50	52.00	86.50
Total Financing	34.50	52.00	86.50
of which IBRD/IDA	30.00	50.00	80.00
Financing Gap	0.00	0.00	0.00

DETAILS - Additional Financing

World Bank Group Financing

International Development Association (IDA)	50.00
IDA Grant	50.00

Non-World Bank Group Financing

Counterpart Funding	2.00
Borrower/Recipient	2.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Gambia, The	0.00	50.00	0.00	50.00
National PBA	0.00	50.00	0.00	50.00
Total	**0.00**	**50.00**	**0.00**	**50.00**

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any other Policy waiver(s)?

[ ] Yes [✓] No

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
Cultural Heritage	Relevant
Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Samuel Lantei Mills	Team Leader (ADM Responsible)	Health Systems Strengthening	HAWH3
Haoussia Tchaoussala	Procurement Specialist (ADM Responsible)	Procurement	EAWRU
Laurent Mehdi Brito	Procurement Specialist	Procurement	EAWRU
Fatou Mbacke Dieng	Financial Management Specialist (ADM Responsible)	Financial Management	EAWG1
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Sophie Lo Diop	Environmental Specialist (ADM Responsible)	Environment	SAWE1
Amadou Ba	Team Member	Finance	WFACS
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Bahie Mary Rassekh	Team Member	Women and Girls' Empowerment	HAWH3
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Toomas Palu	Team Member	Health Insurance	HHNDR
Yassin Saine Njie	Team Member	Operations	AWMGM

Extended Team

Name	Title	Organization	Location

I. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING

A. Introduction

1. **This Project Paper seeks the approval of the World Bank's Board of Executive Directors to provide a grant in the amount of SDR 35.5 million (US$50.0 million equivalent) IDA for an Additional Financing (AF).** The AF would support the cost of expanding activities of the Essential Health Services Strengthening Project (P173287), approved by the Board on October 9, 2020, in an amount of US$30.0 million equivalent IDA. The project entailed a co-financing grant in an amount of US$4.5 million from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The primary objective of the AF is to improve quality and utilization of essential health services in The Gambia.

2. **The need for additional resources was formally conveyed by the Government of The Gambia (GoTG) on August 17, 2021.** The proposed AF will: (a) enable the expansion of performance-based contracting of health facilities nationally, that is, to increase the existing geographical coverage of the five rural regions (with 40 percent of the population) to cover the entire country by including the two western regions (with 60 percent of the population) and enable the rollout of the proposed National Health Insurance Scheme (NHIS); (b) support the construction and equipment of a national emergency treatment center intensive care unit, emergency observation and treatment center, national public health laboratory and training center, and national blood transfusion center, as part of the Government's long-term efforts toward making a sustained and comprehensive pandemic response to coronavirus disease 2019 (COVID-19) and future pandemics through the strengthening of the national system for public health preparedness; and (c) support the renovation and equipment of selected health facilities including safe removal of damaged asbestos roofing sheets, which are leaking and releasing dangerous asbestos fibers into the air.

B. Parent Project Design and Scope

3. **The Project Development Objective (PDO) of the parent project and this AF is to improve quality and utilization of essential health services in The Gambia.** The parent project includes three components: (a) Improving the Delivery and Utilization of Quality Essential Primary Health Care (PHC) Services (US$31.5 million equivalent: US$27.0 million IDA and US$4.5 million from GFATM); (b) Project Management (US$3 million equivalent IDA); and (c) Contingent Emergency Response Component (CERC). The AF will support activities through Component 1 of the parent project.

4. **The Ministry of Health (MoH) is the implementing agency for the project.** The MoH Projects Coordination Unit (PCU) is entrusted with the coordination of project activities, as well as fiduciary tasks of procurement and financial management (FM). The PCU is now fully staffed with a PCU coordinator, senior operations officer, financial controller, senior accountant, five accountants, procurement specialist, procurement officer, and procurement assistant. Given the increasing workload, an operations officer was recently recruited, and a second senior accountant will be recruited by March 2022. The implementation arrangements as stipulated in the Financing Agreement of the parent project (comprised of the National Steering Committee [NSC], Project Implementation Committee [PIC], and PCU are in place and functional. They will continue as the implementation arrangements for the AF.

5. **The existing NSC will continue to provide strategic guidance for the overall project implementation.** The NSC is multidisciplinary, cross-government, and with representation of development partners. Additionally, a PIC, chaired by the Permanent Secretary and comprising the directors of the implementing MoH directorates, Results-based Financing (RBF) Unit senior staff, and PCU senior staff, approves the Annual Work Plans and Budgets (AWPBs) and discusses the annual work plan implementation progress, bottlenecks, and remedial actions in monthly meetings.

C. Project Performance

6. **Progress toward the PDO and overall implementation was rated Satisfactory in the last Implementation Status and Results Report (ISR) of September 21, 2021, and the project continues to make good progress.** As of October 24, 2021, disbursements amount to US$3.22 million (11 percent of commitments) over a one-year period which included initiation of procurement activities.

7. **The overall implementation is rated Satisfactory.** Following project effectiveness, a number of key activities in the AWPB have been initiated. The status of the implementation of the three components is described below.

Component 1: Improving the Delivery and Utilization of Quality Essential PHC Services (US$31.5 million equivalent: US$27.0 million IDA and US$4.5 million from GFATM)

Subcomponent 1.1: Improving the quality of essential PHC delivery using an RBF approach (US$9.5 million IDA)

8. **Support to verification of the quality of services.** The Essential Healthcare Package (EHCP) for each level of the health care delivery system (that is, Village Health Services [VHS], community clinics, minor health centers, major health centers, district hospitals, general hospitals, and the teaching hospital) has been validated and finalized and the costing of the package for all levels has been completed except for the tertiary level. Further, the quality of care checklist is being administered quarterly to gauge progress in the provision of quality health services.

9. **Provision of Performance-based Financing (PBF) grants to health facilities for the delivery of the newly defined EHCP.** The Maternal and Child Nutrition and Health Results Project (MCNHRP), which closed on June 30, 2020 implemented PBF in five regions and the Independent Evaluation Group rated the project outcome as Highly Satisfactory. PBF implementation in these 5 regions continued from July 2020 with funds allocated in the 2020 Government budget to the RBF Unit and in October 2020 when the parent project became effective. In the Project Appraisal Document (PAD) of the parent, the geographical coverage for the PBF under implementation is the same as for the MCNHRP, that is, the five project-supported rural regions (with 40 percent of the population) while the Government Local Fund (GLF) is expected to cover Western Region 1 and Western Region 2 (with 60 percent of The Gambia population). The GMD 50 million (about US$1 million), allocated in the 2021 Government budget to the RBF Unit for the payment of start-up capital and PBF grants to health facilities in Western Region 1 and Western Region 2, training for the initiation of PBF in Western Region 1 and Western Region 2, and the operating expenses of the RBF Unit, is inadequate to cover the expansion of services in Western Region 1 and Western Region 2. In particular, the fund is inadequate to expand the services from the limited maternal and child health and nutrition services covered in the MCNHRP to include other services in the EHCP such as integrated

management of neonatal and childhood illnesses, infectious diseases, noncommunicable diseases (NCDs), and emergency obstetric care. Further, the RBF Unit has conducted the training on RBF for personnel and management of health facilities and training institutions (including Western Region 1 and Western Region 2) as well as Regional Steering Committees (a replica of the NSC at the regional level). Individual bank accounts have been opened for the health facilities in Western Region 1 and Western Region 2 and PBF implementation in these two regions commenced in October 2021 with the allocated GLF.

10. **NHIS.** The NHIS Bill will establish a National Health Insurance Authority to implement a national health insurance scheme, establish a National Health Insurance Fund to pay for the cost of health care services to members of the Scheme, and to provide for the establishment of private health insurance schemes. The sources of funds include two percentage points of the value of all goods and services purchased in The Gambia; reasonable amount on the cost of mandatory international health insurance for every air traveler to The Gambia; five percentage points of taxes levied on telecommunication services; twenty-five percentage points of all taxes on tobacco products; and contributions made by members of the Scheme. The NHIS Bill has undergone First and Second Readings and debate, and a Joint Committee of the National Assembly conducted stakeholder consultations during July 8–11, 2021. The Joint Committee of the National Assembly held its final consultations on the NHIS Bill on October 1, 2021 and an extraordinary session of the National Assembly is scheduled on October 27, 2021 for the presentation of the draft NHIS Bill. Additionally, to facilitate the operationalization of the NHIS Act, a suite of NHIS regulations[1] and various standard operating manuals/guidelines and forms and oaths that are implicated by the Act have been drafted. Until the NHIS Bill is passed, the MoH RBF Unit will continue to serve as the purchaser of health services and will be further strengthened to perform the purchasing role, while the PCU will continue to play the fund-holding role.

Subcomponent 1.2: Community engagement to improve utilization of quality health services (US$1.5 million IDA)

11. Implementation is ongoing for the scale-up and to expand the Social and Behavior Change Communication (SBCC) activities (with a focus on delivery of PHC while also addressing cross-cutting issues such as nutrition, women and girls' empowerment, NCDs, Water, Sanitation and Hygiene [WASH] and climate change) and enhance the grievance redress system. With the assistances of a consultant, target audience analysis has been conducted (including desk review, key informant interviews and focus group discussions) to understand the knowledge, attitudes, practices, and social norms. Stakeholder and beneficiaries' consultations will be organized to inform the development of a SBCC plan/communication strategy. Subsequently, stakeholder consultative workshops will review and gain feedback on the SBCC plan/communication strategy; design messages and develop communication support materials and tools; and pre-test messages and materials with target audiences and key stakeholders to agree on necessary revisions. NCD Policy and costed Strategic Plan have been developed in line with The Gambia National Health Policy (GNHP) and The Gambia National Health Strategic Plan (GNHSP) respectively. MoH has nominated members of a multisectoral Technical Coordination Committee for the preparation and

[1] NHIS Regulations (Part 1 - Interpretation; Part 2 - Governance and Administration; Part 3 - Membership and Registration; Part 4 - Private Health Insurance; Part 5 - Credentialing Healthcare Facilities; Part 6 - Credentialing Healthcare Providers; Part 7 - Quality Assurance; Part 8 - National Health Insurance Tribunal; Part 9 - Public Education; and Part 10 - Schedules).

conduct of a World Health Organization (WHO) STEPwise Approach to NCD Risk Factor Surveillance (STEPS) survey.

Subcomponent 1.3: Building resilient and sustainable health systems to support the delivery of quality health services (US$20.5 million: US$16.0 million IDA and US$4.5 million GFATM)

12. The project is to support the MoH's efforts of Building Resilient and Sustainable Systems for Health (RSSH) through a parallel co-financing of GFATM allocation of US$4.5 million; supporting designated health systems; and strengthening thematic areas such as Health Management Information System (HMIS), Monitoring and Evaluation (M&E), national public health laboratory system, supply chain for the availability of safe medicines and consumables, and human resources for health. The GFATM signed the malaria grant agreement with the MoH on May 21, 2021, which entails US$1.1 million RSSH activities. The GFATM expects to sign a grant agreement with the National HIV/AIDS Secretariat (NAS) in Novemebr 2021, which will entail US$3.4 million RSSH activities. The World Bank-GFATM co-financing agreement under the parent project has been drafted and is expected to be signed in November 2021, following the signing of GFATM-NAS grant agreement.

13. **Health information systems and Civil Registration and Vital Statistics (CRVS).** The MoH indicated its preference for open source software, web-based platforms for establishing health information systems, and interoperability with the existing District Health Information Software 2 (DHIS2). MoH has evaluated the bids for consulting services for an electronic logistics management information system (eLMIS) for selecting a consulting firm. Similarly, Request for Bids (RfB) for an electronic Human Resource Management Information System (eHRMIS) has been issued and RfB for an electronic medical records system is being finalized. Additionally, the project is supporting The Gambia to establish a functional electronic (CRVS) system and improve the coverage of civil registration of vital events (births, deaths, marriages, and divorces). A review of the 1990 Act on Births, Deaths, Marriages and Divorces fed into the drafting of a new CRVS Bill. The project financed the procurement of the following user devices for registration centers across the country: 140 desktops and 60 laptops, 60 tablets, 120 printers, 120 scanners, 140 webcams, 140 UPS 1,000 VA, eight lamination machines, 60 solar bags, 200 Office 365 packages, eight battery backups, and one all-in-one printer. The project has recruited an international electronic civil registration enterprise architect consultant who is providing guidance to the local team.

14. **Renovation of health facilities**. The MoH engaged Masterplan Architects and Engineers, a local architectural firm, to undertake a survey of selected facilities[2] to detect the presence of asbestos products in the buildings. The report indicated damaged asbestos roofing sheets in all of the 13 health facilities/structures surveyed, which are leaking and releasing dangerous asbestos fibers into the air and will require safe removal and disposal. Additionally, the MoH engaged GAP Consultants, a local architectural firm, to provide surveying, architectural, engineering, and quantity surveying services for the design, construction, renovation, and extension of the designated dilapidated health facilities. The health facilities were found to be poorly designed, in bad shape, and not able to cope with the existing services that are being offered at the health facilities. The MoH has also engaged the National Environmental

[2] The 13 facilities that were surveyed for the presence of asbestos are Bansang General Hospital Staff Quarters, Bansang Regional Health Directorate Office and Staff Quarters, Bansang School for Enrolled Nurses and Midwives, Basse District Hospital, Brikama District Hospital, Bwiam General Hospital (old health center), Farafenni Old Health Center, Kaur Health Center, Kiang Karantaba Health Center, Kudang Health Center and Staff Quarters, Mansa Konko Staff Quarters, North Bank East Regional Health Directorate Office and Staff Quarters, and Yorro Bawol Staff Quarters.

Authority (NEA) to provide guidance on the removal and disposal of asbestos. For the Edward Francis Small Teaching Hospital (EFSTH) Pediatric Department to receive accreditation for a Postgraduate Program, a neonatal unit will have to be established next to the maternal unit.

15. **Construction of an emergency treatment center.** The construction of a national emergency treatment center intensive care unit, emergency observation and treatment center, national public health laboratory and training center, national blood transfusion center, and conference center was planned to be jointly financed under the parent project and The Gambia COVID-19 Preparedness and Response Project (P173798). The architectural design and selection of the contractor for the proposed construction at Farato were financed under the COVID-19 Project. The Environmental and Social Impact Assessment (ESIA) as well as the Resettlement Action Plan (RAP) have been developed for final approval by the NEA and the World Bank and are expected to be finalized/disclosed shortly. The RAP implementation is expected to take 11 weeks including payment of compensations to 140 project-affected persons (PAPs), monitoring, and independent evaluation. The GoTG will cater to the proposed payments to the PAPs. Construction is expected to commence in January 2022 after the implementation of the RAP.

Component 2: Project Management (US$3.0 million equivalent IDA)

16. The project is managed and coordinated by the MoH PCU and since September 2020, the PCU has been organizing monthly PIC meetings, chaired by the Permanent Secretary with participation of the Directors of the implementing MoH directorates, RBF Unit senior staff, and PCU senior staff, and has been discussing implementation progress, bottlenecks, and remedial actions.

Component 3: Contingent Emergency Response Component (CERC)

17. Because there is a separate project that is supporting the COVID-19 response and there has not been any other natural or man-made disaster or crisis, the CERC has not been activated.

D. Rationale for Additional Financing

18. **The proposed AF was envisaged during appraisal of the parent project.** In September 2020, during the parent project negotiations, The Gambia Delegation requested an increase in the IDA allocation from US$30.0 million to US$50 million and explained that: (a) the COVID-19 pandemic has contributed to reduced delivery of essential health services which will need to be revamped in the ensuing couple of years; (b) the geographical coverage for the MCNHRP (P143650) which closed on June 30, 2020 was for the five rural regions (with 40 percent of the population) and that increased financing from IDA or other sources will be necessary to establish a NHIS that covers the whole population; and (c) the dilapidated infrastructure needs to be refurbished for the provision of quality health services and to ensure readiness of the health system for future pandemics. However, both the IDA and The Government Delegations agreed that the IDA financing envelope will remain at US$30.0 million with an eye towards AF when additional IDA resources become available in the future.

19. Consequently, the geographical coverage in the parent project design remained the same as for the MCNHRP, instead of expanding to include the urban Western Region 1 and Western Region 2. Additionally, the limited maternal and child health and nutrition services covered in the MCNHRP (P143650) was to be gradually expanded to include other services in the EHCP such as integrated

management of neonatal and childhood illnesses, infectious diseases, NCDs, and emergency obstetric care. Regarding the dilapidated physical infrastructure of health facilities, the plan was to undertake a survey of selected health facilities to prioritize a few for the parent project financing. However, the health hazards (i.e., asbestosis, mesothelioma, and lung cancer) of damaged asbestos products in several facilities make it difficult to prioritize.

20. **There are few development partners in the health sector in The Gambia.** The majority of the funding of GFATM and Gavi (the Vaccine Alliance) is focused on specific disease programs with GFATM supporting HIV/AIDS, tuberculosis, and malaria programs while Gavi supports immunization programs. The United Nations (UN) agencies have been the main implementing partners in the health sector. The World Bank Group (WBG) is the largest financier in the health sector in response to COVID-19. Given the limited GLF, additional WBG financing is critical for strengthening the health care delivery of essential quality health services and for public health pandemic preparedness.

21. **The proposed AF will expand on and complement the activities initiated under the parent project, including:**

- **Expansion of performance-based contracting of health facilities nationally**
- **Contribute to the rollout of the proposed NHIS**
- **Finance renovation and equipment of the dilapidated asbestos-containing health facilities**
- **Construction of national emergency treatment center.** The AF will finance the construction and equipment of a national emergency treatment center intensive care unit, emergency observation and treatment center, national public health laboratory and training center, and national blood transfusion center at Farato.

  The rationale for the construction include a) in March 2020, there was no public health facility adequately equipped to treat COVID-19 cases and the confirmed cases were isolated or treated at hotels that the Government rented for the purpose. Subsequently, The Gambia COVID-19 Preparedness and Response Project (P173798) along with financing from development partners such as United Nations Development Program (UNDP) supported the renovation of the Ndemban Clinic (which had not been used in years) and is now functional as a COVID-19 treatment center but it is inadequate to handle large number of severe cases; b) in March 2020, there was no public health laboratory for COVID-19 testing and the initial cases were tested at the Medical Research Council, a private entity. The COVID-19 project provided support to the National Public Health Laboratory Directorate, which now does the majority of COVID-19 testing; c) there is no national blood transfusion service in the Gambia; d) the 2019 Public Expenditure Review (PER) undertaken by the WBG in collaboration with the Government indicated that it is imperative to improve quality health services to minimize Government expenditure on overseas medical expenses; and e) the MoH has been allocated 32.4 hectares of land at Farato for a future teaching hospital since EFSTH (the only teaching hospital in the country) is dilapidated and congested with no room for expansion for the provision of tertiary services so the proposed construction at Farato will help to initiate the establishment of the future teaching hospital.

The proposed construction at Farato will help fill a critical gap in the national healthcare delivery system. It was to be partly financed by the parent project and The Gambia COVID-19 Preparedness and Response Project (P173798) but the latter is nearly fully disbursed, and the contract price came in at a higher level than expected. The cost of the construction alone after an international competitive bidding is US$22.8 million compared to an originally planned amount of US$10 million. Further, the equipment cost is estimated to be 30 percent of the construction cost. The GoTG, as part of the national COVID-19 response, has allocated US$2 million as counterpart funding toward the cost of the national emergency treatment center at Farato. The design and selection of the contractor for the proposed construction at Farato was completed under the COVID-19 Project.

22. The Table 1 presents a breakdown of the estimated cost of the civil works and sources of financing.

Table 1. Civil Works Cost and Financing (US$, millions)

	Estimated Cost	**Source of Financing**		
Activities		**AF GEHSSP**	**Parent GEHSSP**	**GoTG**
Construction at Farato	22.8	20.8	0	2
Equipment for Farato construction	6.0	6.0	0	0
Farato construction supervision	0.7	0.7	0	0
Health facilities renovation/asbestos removal	14.0	10.0	4	0
Equipment for health facilities renovation	4.5	4.5	0	0
Health facilities renovation/asbestos removal supervision	0.3	0.3	0	0
Total Costs	**48.3**	**42.3**	**4**	**2**

23. **Consistency with the Country Partnership Framework (CPF).** The AF is consistent with the June 2018 Country Engagement Note (Report Number 123654) for FY18–FY21, which has improving nutrition and PHC as one of its focus areas. It is also consistent with the pipeline CPF for The Gambia for FY22–FY26 Focus Area 3.1: Improve the quality and utilization of essential health services.

II. DESCRIPTION OF ADDITIONAL FINANCING

A. Proposed Changes

24. The changes proposed for the AF entail expanding the scope of activities in the parent project, The Gambia Essential Health Services Strengthening Project (P173287) and adjusting its overall design. The implementation arrangements will remain the same. As the proposed activities to be funded under the AF are aligned with the original PDO, the PDO would remain unchanged. The closing date remains the same, that is, August 29, 2025. The IDA financing envelope is proposed to increase from US$30 million to US$80 million plus GoTG counterpart funding of US$2 million and GFATM parallel co-financing of US$4.5 million.

Project Components

Component 1. Improving the Delivery and Utilization of Quality Essential PHC Services (US$83.5 million equivalent: US$27.0 million from IDA; US$4.5 million from GFATM; AF of US$50.0 million from IDA; and US$2.0 million from GoTG)

Subcomponent 1.1: Improving the quality of essential PHC services delivery using a RBF approach (US$14.5 million: US$9.5 million from IDA; and AF of US$5.0 million from IDA)

25. The proposed AF will support an expansion of performance-based contracting of health facilities nationally, that is, to increase the existing geographical coverage of the five rural regions (with 40 percent of the population) to cover the entire country by including the two western regions (with 60 percent of the population). The AF will also fund activities to enable the rollout of the proposed NHIS.

26. Activities under this subcomponent will support the delivery of quality and essential health services at each level of the health care delivery system (that is, VHSs, community clinics, minor health centers, major health centers, district hospitals, general hospitals, and the teaching hospital). This subcomponent will finance (a) provision of PBF grants to health facilities for the delivery of the newly defined EHCP; (b) support for verification of the quality of services; and (c) enhancing of capacity for the expansion of RBF nationally. The limited maternal and child health and nutrition services covered in the MCNHRP (P143650) will gradually be expanded to include other services in the EHCP such as integrated management of neonatal and childhood illnesses, infectious diseases, NCDs, and emergency obstetric care.

27. As stipulated in the NHIS Bill, the proposed National Health Insurance Authority (NHIA) will be the purchaser of services delivered by health facilities, including community clinics. However, before the establishment of the NHIA, the MoH RBF Unit will assume the role of the purchaser of health services, and the MoH will ensure a smooth transition. Because the majority of the funds for the NHIS will be from taxes and levies as stipulated in the NHIS Bill, the project PBF grants to health facilities will help lay the ground and ensure smooth transition for the implementation of the NHIS payment mechanisms. If the NHIS Bill is not passed by the National Assembly, the MoH RBF Unit will continue to serve as the purchaser of health services and will be further strengthened to perform the purchasing role, while the PCU will continue to play the fund holding role.

28. This subcomponent will also support capacity building for the expansion of RBF nationally on purchasing and verification (first line and second line) of services. This will entail technical assistance for establishing the NHIA processes for (a) electronic enrollment (health insurance membership cards and means testing); (b) electronic claims processing system; and (c) performance-based contracting of health facilities with a focus on quality of care and delivering the EHCP. A national RBF operational manual has been updated and incorporated in the Project Operations Manual (POM).

Subcomponent 1.2: Community engagement to improve utilization of quality health services (US$4.2 million: US$1.5 million from IDA; and AF of US$2.7 million from IDA)

29. The description of Subcomponent 1.2 remains the same in the parent project and the AF of US$2.7 million will support the scaling up of the activities in the parent project.

30. The activities proposed in this subcomponent aim to scale up and expand the SBCC activities that were highly successful in improving the utilization of health services and health outcomes under the previous project. The SBCC Program will focus on prevention activities and delivery of PHC and will also address cross-cutting issues such as nutrition, women and girls' empowerment, NCDs, WASH, and climate change. Additionally, a grievance redress system will be developed to address complaints and grievances in a timely, effective, and efficient manner and it will build on the call center established for COVID-19 pandemic response to ensure that project beneficiaries have multiple channels to report grievances or suggestions such as the toll-free number (#1025), direct contact with the health personnel, a suggestion box at health facilities, MoH website, a Facebook page, and SMS.

Subcomponent 1.3. Building resilient and sustainable health systems to support the delivery of quality health services (US$62.8 million: US$16.0 million from IDA; US$4.5 million from GFATM; and AF of US$42.3 million from IDA)

31. The AF will support (a) the construction, equipment, and construction supervision of the proposed national emergency treatment center intensive care unit, emergency observation and treatment center, national public health laboratory and training center, and national blood transfusion center, and (b) renovation and equipment of selected health facilities including safe removal of damaged asbestos roofing sheets. Energy-efficient measures will be put in place to reduce greenhouse gas (GHG) emissions such as the procurement of energy-efficient equipment and materials for renovations[3] as well as climate-resilient materials to mitigate flood risks and climate-related emergencies.

32. GFATM has allocated US$4.5 million, as part of a parallel co-financing arrangement with the World Bank, to support designated health systems strengthening thematic areas such as HMIS, M&E, national public health laboratory system, supply chain for the availability of safe medicines and consumables, and human resources for health.

33. The subcomponent will support an NCD risk factor survey to define an NCD strategy and update the composition of the essential package of services and will also support the production of survey data for the monitoring of the essential health services coverage index.

Component 2. Project Management (US$3.0 million equivalent IDA)

34. The proposed project will be managed and coordinated by the MoH PCU including FM and procurement, M&E, environmental and social (E&S) risks management compliance, and assessment of implementation progress. The project will share the operating costs of the PCU (including salaries for project staff, office space, utilities, supplies, and transport) with other development partners such as GFATM. The capacity of the PCU and MoH staff will be enhanced with a combination of on-the-job training and short courses. Further, the MoH budget management and fiduciary management systems will be strengthened.

[3] These can include energy-efficient features such as efficient ventilation systems, temperature and humidity controls, low-energy lighting, energy-efficient and low-carbon construction material, and use of modern and efficient water supply and treatment.

Component 3. Contingent Emergency Response Component (CERC)

35. This component enables the rapid reallocation of project proceeds in 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. A detailed CERC Operational Manual has been developed and included in the POM.

36. **Component Costs.** The increase in scope as outlined above is reflected in an increase in indicative Component 1 allocation from US$31.5 million to US$83.5 million, with the full amount of the AF being added under Component 1 (Table 2).

Table 2. Project Cost and Financing (US$, millions)

Project Components	Parent Project Cost	GFATM	AF Cost	GoTG	Total Cost
Component 1. Improving the Delivery and Utilization of Quality Essential PHC Services	27.0	4.5	50.0	2.0	83.5
Component 2. Project Management	3.0	0.0	0.0	0.0	3.0
Component 3. Contingent Emergency Response Component (CERC)	0.0	0.0	0.0	0.0	0.0
Total Costs	**30.0**	**4.5**	**50.0**	**2.0**	**86.5**

37. **Implementation arrangements.** The implementation/institutional arrangements in place for the parent project will be applicable to the proposed AF.

38. **Disbursement.** In the parent project Financing Agreement, the disbursement category regarding Subcomponent 1.3 (for goods, works, non-consulting services, consulting services, training, and operating costs) is proposed to be changed: the percentage of expenditures to be financed will change from 55 percent to up to 100 percent in line with the World Bank-GFATM parallel co-financing agreement.

39. **Results Framework.** The PDO and PDO-level indicators remain unchanged. The targets for the PDO-level and intermediate-level indicators in the parent project for essential health service provision are already national targets so there is no need to revise them. In the parent project design, the GLF is to pay PBF grants to health facilities in Western Region 1 and Western Region 2 while the project supports capacity building for the expansion of RBF nationally on purchasing and verification (first line and second line) of services. Since the indicator, number of people who have received essential health, nutrition, and population services (along with its breakdown indicators), are measured based on contribution rather than attribution, the parent project which is contributing to the RBF nationally merited the use of national targets in the parent project design. The proposed changes to the project Results Framework regarding the intermediate results indicators is described as follows.

Component 1

- Electronic logistic management information system established (text) - New indicator
- Health facilities renovated (number) - to change to ‘Health facilities renovated/constructed (number)’ and increase the target from 4 to 13 with one breakdown indicator:

  - National emergency treatment center intensive care unit, emergency observation and treatment center, national public health laboratory and training center, national blood transfusion center, and conference center constructed (Number)
- National blood transfusion center constructed (Text) – for deletion since it is incorporated in the new breakdown indicator noted above.
- Health facilities renovated/constructed with energy efficient systems in place and/or with energy-efficient appliances installed (Number), target of 10 health facilities - New indicator
- Marriages registered (number) – to change baseline value from 5,000 to 490 and the endline target to 5,500
- Grievances responded to within stipulated service standards for response (Percentage) - to change to 'Grievances addressed within stipulated service standards for response (Percentage)' and increase the target from 50 to 90.

B. Sustainability

40. The GoTG's demonstrated commitment to achieving universal health coverage (UHC) increases the likely sustainability of the project. To improve institutional sustainability, the project is enhancing the management and technical capacity of the MoH and PCU staff to implement the project. Regarding financial sustainability, since 2019, the GoTG has been allocating funds in its annual budget to RBF with GMD 50 million (about US$1 million) allocated to RBF in the 2021 Government budget and additional US$2 million of the 2021 GLF was allocated to the NHIS. It is envisaged that the Government will continue to increase allocation to the NHIS given the various sources of funds stipulated in the NHIS Bill.

III. KEY RISKS

41. **The overall risk to achieving the PDO with the expanded scope and AF is Moderate**.

42. **The large-scale construction at Farato entails certain significant risks**. The proposed construction of the national emergency treatment center intensive care unit, emergency observation and treatment center, national public health laboratory and training center, national blood transfusion center, and conference center, at Farato is the largest ever single construction in the health sector. There are risks in selecting a suitable site, identifying competent architects for the design, selecting a contractor with a good track record and proper supervision of the construction. The following mitigations measures have been undertaken by the MoH: (a) the Government has allocated 32.4 hectares of land at Farato for the construction, which will cover an area of about 4 hectares. As part of the COVID-19 project (P173798), ESIA and RAP have been prepared and are expected to be finalized/disclosed shortly and the Government have allocated GMD 775,0478 (about US$16,231) for the implementation process, including compensation of about 140 PAPs, restoration of their livelihood, capacity building of the farmers in business management, assistance to vulnerable persons, the replacement of the lost "green cover" and M&E of the RAP; (b) an international (IDOM) and local (GAP Consultants) architectural firms were competitively recruited last year and the detailed designs were timely completed; (c) the selected contractor Shapoorji Pallonji Mideast (L.L.C.) has extensive international experience with local representation. Contract negotiations has been done for proposed commencement of construction in January 2022; and (d) the same firms that developed the designs will do the construction supervision.

Further, an international medical equipment firm has been contracted and the technical specifications of have already developed and will be fine-tuned prior to issuance of RfBs.

43. **Political and governance risks are assessed as Moderate.** The political coalition established in late 2016 after President Barrow assumed office was fragile and the next presidential elections will be held on December 4, 2021. The Government continues to show commitment to the health sector reform agenda, particularly as it relates to RBF and NHIS, and both the Ministry of Finance and Economic Affairs (MoFEA) and MoH are actively engaging the National Assembly for the enactment of the draft NHIS Bill. The MCNHRP contributed to improving the utilization and quality of health care services which is in line with the PDO of the proposed project.

44. **Macroeconomic risks are assessed as Moderate.** A prolonged COVID-19 pandemic will increase pressure on external and fiscal balances over the medium term. This could lead to less budgetary allocation to health and substantial risk to RBF and NHIS sustainability. Nevertheless, the Government budgetary allocation to RBF increased from US$0.8 million in 2020 to US$1.0 million in 2021 and US$2.0 million was allocated to the NHIS. Additionally, the GoTG has already allocated the counterpart funding of US$2.0 million noted above. In the 2021 AWPB submitted in November 2020, the project activities were frontloaded until the Government's allocation increases in subsequent years as the economy recovers from the effects of the COVID-19 pandemic.

45. **Institutional capacity for implementation and sustainability risks is assessed Moderate.** The PCU had limited experience working on WBG operations but is implementing the parent project and The Gambia COVID-19 Preparedness and Response Project (P173798). Before the COVID-19 Project, the last WBG-financed project implemented by the MoH was The Gambia Participatory Health, Population, and Nutrition Project (P000825), which was approved on March 2, 1998, and closed on June 30, 2005. The senior management team was fully engaged in the AF preparation and has become familiar with WBG procedures and policies. Further, the PCU is staffed with a PCU coordinator, a senior operations officer, an FM specialist, a senior accountant, five accountants, a procurement specialist, a procurement officer, and a procurement assistant; the same PCU staff have been managing The Gambia COVID-19 Preparedness and Response Project which is rated Satisfactory for both the PDO and implementation progress; and the PCU continues to receive hands-on training. Given the increasing workload, an operations officer was recently recruited, and a second senior accountant will be recruited.

46. **Fiduciary risks associated are** assessed **Moderate.**

(a) **Procurement.** Full-time PCU procurement specialist, procurement officer, and procurement assistant will continue to provide procurement support to the project during implementation. Procurement training has been provided to the PCU staff. A contracts committee—which is chaired by the Permanent Secretary (or designee) and comprises the Director of the Directorate of Planning and Information (DPI), Director of Directorate of National Pharmaceutical Services, PCU coordinator, PCU financial controller or senior accountant, PCU procurement staff with the PCU procurement specialist as secretary, and PCU senior operations officer—meets weekly to review the procurement activities.

(b) **FM.** The FM team consisting of a financial controller, a senior accountant, and five accountants is adequate and able to manage the proposed AF. The following mitigation

measures noted in the PAD of the parent project have been undertaken: (a) the accounting software has been customized to include bookkeeping of the project and generate interim financial reports (IFRs); (b) Memorandum of Understanding with the MoFEA Directorate of Internal Audit has been signed to cover all World Bank-financed projects; (c) the FM Unit has received on-the-job training on World Bank FM procedures; and (d) an external auditor has been recruited.

47. **E&S risks are rated Moderate.** The measures to address E&S risks presented in the original project remain relevant. Regarding environmental factors, the renovations/constructions/removal of asbestos of health facilities have the potential to have negative impacts such as noise, dust emissions, release of dangerous asbestos fibers into the air, generation of solid and liquid waste, and health and safety issues. To respond to the environmental, social, health, and safety impacts, various instruments noted in the appraisal summary have been developed for implementation. Further, activities under Subcomponent 1.3 of the AF will support the removal of asbestos of 13 health facilities/structures. These activities present risks of negative impacts to the environment and human health. Accordingly, an Asbestos Remedial Action Plan will be completed to manage the handling, removal, transport and disposal of all asbestos materials for each of the health facility renovations. This Plan is being developed by the MoH along with NEA and World Bank environmental specialists and will be incorporated into the ESMF. On the social side, no new risk categories are expected from the additional activities. A comprehensive Gender-based Violence, Sexual Exploitation and Abuse, and Sexual Harassment (GBV/SEA/SH) Action Plan has been developed and is being implemented. As noted earlier, a RAP was developed for the national emergency treatment center as part of the COVID-19 project (P173798) for compensation of PAPs, and no additional resettlement is expected.

IV. APPRAISAL SUMMARY

A. Economic, Financial, and Technical Analysis

48. The parent project along with proposed AF development impact, rationale for public investment, and World Bank value added are summarized in the following paragraphs.

Development Impact

49. **The project would contribute to economic growth through direct contribution to productivity, accumulation of physical output through savings rates, and indirect contribution to human capital.** The project’s theory of change envisages that in the long term, it would contribute to improvement of The Gambia’s 2020 Human Capital Index (HCI) (estimated to be 0.42). This could be achieved through improvements in the health status of the population by reducing the maternal mortality ratio and under-five mortality rate. Unlike the traditional input-based financing, the proposed project would address key constraints to effective service delivery by performance-based contracting, which is expected to lead to improved health outcomes.

50. **In line with the PDO and costs associated with project interventions, a cost-benefit analysis (CBA) (that is, determining whether dollar benefits of the project are likely to outweigh dollar costs) was carried out to determine the viability of the parent project and the proposed AF.** The analysis was

built around the PDO which aims at improving the quality and utilization of essential health care services. Since the AF will support the scaling up of the activities in the parent project (i.e., Improving the quality of essential PHC delivery using a RBF approach and renovation of selected health facilities) plus proposed new construction and equipment of a national emergency treatment center intensive care unit, emergency observation and treatment center, national public health laboratory and training center, and national blood transfusion center, a CBA was carried out to cover both the parent project and the proposed AF. This CBA replaces the previous one in the parent project.

51. **In the base case scenario, the net present value (NPV) of the entire project is US$102.7 million,** and its internal rate of return (IRR) is 48.62 percent, which exceeds the discount rate of 6 percent used for this analysis. Additionally, the NPV remains **positive** even when the impact on averted Disability Adjusted Life Years (DALYs) is reduced to 5 percent (Table 3). The results show that the proposed activities to be undertaken with the AF will be economically viable (See Annex 1 for details).

Table 3: Results of CBA Base-case Scenario and Sensitivity Analyses

	DALY reduction rate (%)	NPV (US$, millions)	IRR (%)
High case scenario	15	196.55	95.15
Base-case scenario	10	102.70	48.62
Low-case scenario	5	8.84	9.68

Public Sector Involvement

52. **Public intervention is needed to address the following four major causes of market failures: equity, externalities, public good, and market power.** With the high urban-rural and wealth quintile disparities in the provision of essential health services, the equity consideration is perhaps the most important factor in The Gambia. Access to health care professionals is skewed heavily toward the urban rather than the rural setting, as 73 percent of health care professionals practice in facilities in urban areas.[4] Moreover, a core tenet of UHC is to protect individuals from financial consequences of ill health. As such, market-driven user fees, for instance, for health services could either deter patients from using needed services or they may get services but at a cost which could impoverish them or their families. These constraints could be better addressed by the public sector as the market cannot realistically address access and coverage issues through a price mechanism. Public intervention is, therefore, necessary to deal with large variable costs associated with disparities of health care providers across the country. Besides, the project's proposed performance-based contracting approach would help address systemic services delivery issues that might not be attractive to the profit-oriented private sector.

Value Added of World Bank

53. Details of the World Bank value added are described in section D. Rationale for AF.

B. Financial Management

54. In line with the guidelines stated in the FM Practices Manual issued by the FM Sector Board on March 1, 2010 (last updated Septmeber 2021), an FM assessment was conducted for the parent project.

[4] The Gambia Health PER 2019.

The FM arrangements for this AF will be the same as those under the parent project, including the FM risk assessed, which is Moderate. As all mitigating measures identified have been implemented for the parent project to address FM capacity constraints, the FM satisfies the WBG's minimum requirements.

55. The overall FM performance of the PCU is Moderately Satisfactory in the September 2021 ISR due to (i) long outstanding unretired imprest issued to implementing officers; (ii) rate paid for transport refund, and daily subsistence allowance not consistent with the rates in the FM manual and accounting procedures; and (iii) delay in the submission of the internal audit reports. However, some significant progresses were noted during the October 2021 mission. For instance, the external auditor has been recruited, the fixed assets registry has been updated, and the MoFEA Directorate of Internal Audit has submitted a draft report. The un-audited IFRs for the ongoing projects are submitted on time and acceptable to IDA. As noted earlier, an additonal senior accountant will be recruired due to the increased workload.

56. **Several measures will be taken to accommodate the AF in the existing FM system and ensure readiness for implementation**: (i) the accounting software used for the parent project will be updated for the bookkeeping of the AF activities; (ii) the external auditor contract will be amended to include the AF in its audit scope; and (iii) the MoFEA Directorate of Internal Audit will include the AF in its scope of intervention.

57. Disbursement for the project will follow the existing disbursement arrangements for the original project. Disbursements under the ongoing project are statement of expenditure based. Direct Payment method will apply as appropriate. A pooled designated account will be used for the AF.

C. Procurement

58. Procurement under the AF will be carried out in accordance with the World Bank's Procurement Regulations for IPF Borrowers, dated November 2020. As with the parent project, the AF will be subject to the World Bank's Anticorruption Guidelines, dated October 15, 2006, revised in January 2011, and as of July 1, 2016. The project will use the Systematic Tracking of Exchanges in Procurement (STEP) to plan, record, and track procurement transactions.

59. The Project Procurement Strategy for Development and the Procurement Plan in STEP have been updated to reflect the additional procurement activities. The major procurement under the AF is medical equipment for the national emergency treatment center intensive care unit, emergency observation and treatment center, national public health laboratory and training center, national blood transfusion center, and conference center. The selection and contracting of the contractor along with supervision consulting services for the construction and medical equipment were undertaken under The Gambia COVID-19 Preparedness and Response Project (P173798).

D. Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

E. Environmental and Social

60. E&S compliance of the parent project is Satisfactory. The parent project E&S instruments have been updated for the proposed AF and have been publicly disclosed:

- AF Environmental and Social Commitment Plan (ESCP) - AF to The Gambia Essential Health Services Strengthening Project - P177263 (English), October 18, 2021
- AF Stakeholder Engagement Plan (SEP) - AF to The Gambia Essential Health Services Strengthening Project - P177263 (English), October 18, 2021
- AF Environmental and Social Review Summary (ESRS) - AF to The Gambia Essential Health Services Strengthening Project - P177263 (English), October 18, 2021
- AF Environmental and Social Management Framework (ESMF) The Gambia Essential Health Services Strengthening Project (P173287) (English)*,* October 26, 2021

61. Additionally, the ESIA and RAP for construction of the national emergency treatment center intensive care unit, emergency observation and treatment center, national public health laboratory and training center, national blood transfusion center, and conference center were developed under The Gambia COVID-19 Preparedness and Response Project (P173798). The RAP and ESIA and are expected to be finalized/disclosed shortly.

62. Further, the MoH has developed a comprehensive GBV/SEA/SH and Grievance Redress Mechanism (GRM) Action Plan, which is under implementation. The project implementation will ensure appropriate stakeholder engagement, proper awareness raising, and timely information dissemination.

63. The PCU has a Senior Operations Officer who is the main coordinator and focal point for E&S issues, supported by the MoH Environmental Health Program Manager, the Health Communications Manager and the SEA/SH/GBV Focal Point. Implementation of the E&S agenda has been satisfactory. The same PCU has been implementing the E&S requirements of The Gambia COVID-19 Preparedness and Response Project (P173798) since April 2020 and the parent project.

64. As part of the PCU commitment to monitor and report on the status of E&S due diligence, E&S Due Diligence Reports are submitted quarterly to the WBG. Together with the WBG E&S specialists, the report has been structured to follow both the ESCP and ESMF commitments. All required project actions are being tracked and reported on. The WBG has organized a series for virtual capacity-building events: (a) a virtual orientation on November 17, 2020, for 37 key stakeholders working on this project to ensure an appropriate E&S Due Diligence Report is carried out; (b) three-day training (December 1–3, 2020) on implementing the E&S framework in WBG-financed projects for implementing agencies; (c) workshop on SEA/SH risk management in World Bank-financed operations in The Gambia during December 8–10, 2020; and (d) training on May 26, 2021, for more than 24 participants and the topics covered included expanding the stakeholder communication program, ESMPs, SEA/SH Action Plan, and HCW treatment. The E&S management practices across the World Bank and MoH programs were presented as good practice in a three-day Health E&S training for Sierra Leone, Liberia, and Ghana.

65. **The AF will contribute to two World Bank Regional Gender Action Plan priorities: (i) reduce adolescent fertility rate (with the tracking of the PDO-level indicator, contraceptive prevalence rate); and (ii) reduce GBV (as noted above with the implementation of the comprehensive SEA/SH/GBV action plan)**. Globally, some progress on women's rights has been achieved. The maternal mortality ratio (MMR) has decreased by 36 percent, from 932 maternal deaths per 100,000 live births in 2000 to 597 per 100,000 live births in 2017. This is inversely correlated with the proportion of births attended by skilled health personnel, which increased from 44.1 percent in 1990 to 56.6 percent in 2010 and to 82.7 percent in 2018. However, work still needs to be done in The Gambia to achieve gender equality. The proportion of women ages 20–24 who were married or in union before age 18 is 30.4 percent. As of February 2019, only 10.3 percent of parliament seats are held by women. In 2013, 7 percent of women ages 15–49 reported that they had been subject to physical and/or sexual violence by a current or former intimate partner in the previous 12 months. Moreover, women of reproductive age (ages 15–49) often face barriers with respect to their sexual and reproductive health and rights—despite progress, the proportion of women using modern contraceptive methods stood at 17.1 percent in 2020.

66. In The Gambia, only 35.7 percent of indicators needed to monitor the Sustainable Development Goals (SDGs) from a gender perspective are available, with gaps in key areas such as unpaid care and domestic work, key labor market indicators such as gender pay gap, and skills in information and communication technology. In addition, many areas such as gender and poverty, women's access to assets including land, physical and SH, and gender and the environment currently lack comparable methodologies for comprehensive and periodic monitoring. These gender data help understand the situation of women and girls in The Gambia and for achieving the gender-related SDGs commitments, and efforts are under way to address these gaps.

67. **GRM.** The parent project incorporates a comprehensive project-wide GRM which will enable a broad range of stakeholders to channel concerns, questions, and complaints to the various implementation agencies and toll-free call center. The project supports the call center with toll-free numbers. These numbers have been publicly disclosed throughout the country in the broadcast and print media. The GRM has been equipped to handle cases of SEA/SH, as rapid guidance on how to respond to these cases has been developed and shared with operators. This will follow a survivor-centered approach. The GRM will continue to be publicized by the MoH and other relevant agencies.

Climate Vulnerability and Resilience

68. **This project has been screened for climate change and disaster risks.** The overall potential risks in The Gambia were assessed 'Moderate' in the Summary Climate and Disaster Risk Screening Report. The exposure rating was assessed 'High' due to extreme temperature, precipitation and flooding, drought, sea level rise, storm surge, and coastal erosion. This exposure risk is assessed at this level for both the current and future time scales. An increase in heat and rainfall events may lead to food insecurity due to the population's heavy reliance on rain-fed crops that are vulnerable to persistent drought.[5] Droughts can also lead to dust storms, which would have serious respiratory health consequences for a population that has lower respiratory tract infections as the second leading cause of mortality in 2019.[6] Extreme rainfall

[5] International College of Business and Human Resource Development (ICOBAHRD) at Kanifing and the Center for International Earth Science Information Network (CIESIN) at Columbia University. 2011. Climate Change and Development in The Gambia: Challenges to Ecosytem Goods and Services. Kanifing, The Gambia.
[6] IHME. 2019. Country Profile: The Gambia. Retrieved at: *http://www.healthdata.org/gambia*

events and flooding may lead to an increased number of breeding grounds for mosquitoes, water contamination, injuries, drowning, and infrastructure damage. Therefore, it is critical to put sustainable and climate-resilient measures in place to reduce the impact of climate change on the population. However, the risk on project activities and outcomes is categorized 'Moderate' due to several adaptation measures to ensure climate resilience in the future. Some mitigation measures will also be put in place to reduce the impact of the project's activities on the environment and reduce GHGs.

69. **Climate change is a suspected culprit increasing pressure on healthcare system in The Gambia.** Climate forecasts indicate that mean annual temperature, tropical nights and annual precipitation will increase in The Gambia due to climate change[7]. These, in turn, will increase the risk of cardiovascular diseases and epidemiological risk associated with some vector-borne pathogens. Growing body of epidemiological evidence in Africa suggests that temperature increase and changes in precipitation patterns contribute to preterm births, low birth weight (LBW), stillbirths, growing antibiotic resistance, hypertension, and other health complications, including teratogenic effects in fetuses from heat exposure in the first trimester of pregnancies[8]. Very high risk of major infectious diseases is present in The Gambia: bacterial and protozoal diarrhea, hepatitis A, and typhoid fever, malaria and dengue fever, schistosomiasis, rabies, and meningococcal meningitis. Resistant strains of pathogens exacerbate these epidemiological hazards. Next group of population vulnerable to climate change are those suffering from non-communicable diseases, such as cardiovascular diseases associated with hypertension. Rural and semi-urban residence in Gambia were recently found to be strongly associated with hypertension. One of possible factors contributing to hypertension in rural and semi-urban regions in The Gambia is heat exposure, which is likely to become more severe with climate change[9]. Pregnant women, especially in rural areas, are subjected to extreme heat while working outdoors during pregnancy[10]. According to demographic and health survey (DHS) from 2013, maternal mortality accounts for 36 per cent of all deaths among women in the age cohort of 15 to 49 years old. The neonatal mortality is on declining trend, still quite high at 27 deaths per 1000 of live births[11,12]. Over 60 percent of population are below 25 years old, and approximately half of this young generation are females of childbearing age. Over 30 percent of country population will be vulnerable to climate-related health complications in the coming decades and will need healthcare services.

70. Improved provision of health services and stronger trust in new and/or renovated healthcare facilities will enable collection of robust data, better monitoring of health statistics and obtaining reliable epidemiological information for both communicable and non-communicable diseases, including those potentially linked to climate change. While frequency of communicable and non-communicable diseases in The Gambia could increase in association with and/or exacerbated by the climate change, it is crucial that the country builds resilience through strengthening its healthcare services. Old structures used in

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[7] The Gambia, Climate Projections. The World Bank Climate Change Knowledge Portal - *https://climateknowledgeportal.worldbank.org/country/gambia/climate-data-projections*
[8] Bonell A. et al. (2020) A protocol for an observational cohort study of heat strain and its effect on fetal wellbeing in pregnant farmers in The Gambia - *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7141168/*
[9] *Cham B. et al. (2018) Burden of hypertension in The Gambia: evidence from a national World Health Organization (WHO) STEP survey. International Journal of Epidemiology, pp. 860-871.*
[10] Ibid
[11] Mortality rate, neonatal (per 1,000 live births) – Gambia, The *https://data.worldbank.org/indicator/SH.DYN.NMRT?locations=GM*
[12] Gambia Maternal and Child Health, UNICEF - *https://www.unicef.org/gambia/maternal-and-child-health*

healthcare sector are losing structural integrity and ability to protect against the heat waves, windstorms, heavy rains, and floods. The proposed AF and the parent project aim to prepare the country's healthcare sector in advance to the challenge and risks posed by the climate change.

71. The proposed AF will also increase climate resilience of healthcare facilities during heat waves. New materials used in renovations and constructions of healthcare facilities will have at least as good or better fire-retardant properties, as asbestos materials previously used in roofing and flooring. The proposed project will contribute towards climate change adaptation co-benefit by improve resilience to extreme heat and minimize the risk and damages from fires. Renovated and newly constructed facilities will have improved energy efficiency, some will partially rely on on-site renewable energy generation and will adopt measures to minimize resource consumption and reduce CO_2 emissions.

72. Healthcare sector capacity-building activities are also envisaged in the project design. Under Component 1: Improving the Delivery and Utilization of Quality Essential PHC Services, activities will be expanded into the two urban regions of the country, where 60 percent of the population of The Gambia resides. In addition to the overarching effort to increase climate resilience of healthcare sector in the Gambia detailed above, simultaneous capacity building of healthcare workers will be directly facilitated through this operation. Climate change resilience measures will help raise awareness about the impacts of climate change on communicable and non-communicable diseases, and nutrition. This can include training among healthcare professionals and general public on measures to take in the event of extreme heat or drought to reduce the chances of dehydration, hypertension, and prevent deaths from heat waves that can aggravate chronic cardiovascular and respiratory diseases. Special attention will be given to capacity-building for addressing and responding to pre- and post-natal and health complications due to heat exposure, hypertension or communicable diseases. Moreover, SBCC will also be expanded into the two urban regions and context-specific training material and messages will also be developed and tailored for community members and health care providers, which will include contextual information on climate change and climate resilience. The call center that was established in the country is part of the early warning system mechanism, will enable the population to provide any information related to climate impacts or disasters, particularly due to the climate variability that the country experiences every few years; and excessive rainfall that leads to flooding. This will enable emergency health personnel to mobilize quickly to address climate disasters to reduce injuries, drownings and deaths.

73. In terms of climate mitigation activities, the AF will finance several activities under Component 1: Improving the Delivery and Utilization of Quality Essential PHC Services. The AF will support (a) the climate-smart, energy-efficient and low-carbon renovation as well as the construction of a national emergency treatment center intensive care unit, emergency obstetric treatment center, national public health laboratory and training center, and a national blood transfusion center. This will include use of energy-efficient material including thermal insulation, solar-reflective roofs, efficient ventilation systems, temperature and humidity controls, low-energy lighting (such as diming and occupancy sensors) and use of modern and efficient water supply and treatment. The AF will also finance the removal and proper disposal of asbestos-containing material in several facilities due to the health hazards (i.e., asbestosis, mesothelioma, and lung cancer). Moreover, the AF will procure energy-efficient medical equipment thereby reducing GHGs through reduced energy use for all facilities listed above.

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 GRMs 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/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VI SUMMARY TABLE OF CHANGES

	Changed	Not Changed
Results Framework	✓	
Components and Cost	✓	
Reallocation between Disbursement Categories	✓	
Procurement	✓	
Implementing Agency		✓
Project's Development Objectives		✓
Loan Closing Date(s)		✓
Cancellations Proposed		✓
Disbursements Arrangements		✓
Legal Covenants		✓
Institutional Arrangements		✓
Financial Management		✓
APA Reliance		✓
Implementation Schedule		✓

VII DETAILED CHANGE(S)

COMPONENTS

Current Component Name	Current Cost (US$, millions)	Action	Proposed Component Name	Proposed Cost (US$, millions)
Component 1. Improving the Delivery and Utilization of Quality Essential Primary Health Care Services	32.00	Revised	Component 1. Improving the Delivery and Utilization of Quality Essential Primary Health Care Services	83.50
Component 2. Project	3.00		Component 2. Project	3.00

management			management	
Component 3. Contingent Emergency Response Component (CERC)	0.00		Component 3. Contingent Emergency Response Component (CERC)	0.00
TOTAL	**35.00**			**86.50**

REALLOCATION BETWEEN DISBURSEMENT CATEGORIES

Current Allocation	Actuals + Committed	Proposed Allocation	Financing % (Type Total)	
			Current	Proposed
IDA-D7310-001 | Currency: XDR				
iLap Category Sequence No: 1	Current Expenditure Category: PBF Grants prt 1ai Project			
5,000,000.00	0.00	5,000,000.00	100.00	100.00
iLap Category Sequence No: 2	Current Expenditure Category: GD,Wk,N/CS,Tr,OC prt 1aii,iii,1b&2			
12,000,000.00	829,510.92	12,000,000.00	100.00	100.00
iLap Category Sequence No: 3	Current Expenditure Category: GD,Wk,N/CS,Tr,OC prt 1c Project			
4,200,000.00	24,855.44	4,200,000.00	55.00	100.00
iLap Category Sequence No: 4	Current Expenditure Category: Emergency Expendtures prt 3 Project			
0.00	0.00	0.00	0.00	0.00
Total 21,200,000.00	**854,366.36**	**21,200,000.00**		

Expected Disbursements (in US$)

Fiscal Year	Annual	Cumulative
2021	3,221,262.00	3,221,262.00
2022	7,500,000.00	10,721,262.00
2023	20,600,000.00	31,321,262.00

2024	22,200,000.00	53,521,262.00
2025	16,300,000.00	69,821,262.00
2026	10,178,738.00	80,000,000.00

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Latest ISR Rating	Current Rating
Political and Governance	Moderate	Moderate
Macroeconomic	Moderate	Moderate
Sector Strategies and Policies	Moderate	Moderate
Technical Design of Project or Program	Moderate	Moderate
Institutional Capacity for Implementation and Sustainability	Moderate	Moderate
Fiduciary	Moderate	Moderate
Environment and Social	Moderate	Moderate
Stakeholders	Moderate	Moderate
Other		
Overall	Moderate	Moderate

LEGAL COVENANTS – AF to The Gambia Essential Health Services Strengthening Project (P177263)

Sections and Description
No information available

Conditions

VIII. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: Gambia, The

AF to The Gambia Essential Health Services Strengthening Project

Project Development Objective(s)

To improve quality and utilization of essential health services in The Gambia.

Project Development Objective Indicators by Objectives/ Outcomes

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Improve quality of essential health services							
Health Facility Quality Index (Percentage)		69.00	72.00	75.00	79.00	82.00	85.00
Improve utilization of essential health services							
Essential health services coverage index (Geometric means of tracer indicators, on a scale of 0-100) (Percentage)		45.90	47.55	49.78	52.13	54.46	56.38
Contraceptive prevalence rate (Percentage)		17.10	19.00	22.00	26.00	30.00	33.00
Antenatal care, four or more visits (Percentage)		78.50	80.00	81.00	82.00	83.00	84.00
Delivery in a health facility (Percentage)		83.70	84.00	85.00	86.00	87.00	88.00
Fully immunized children (percentage of children who		84.60	85.00	86.00	87.00	88.00	90.00

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
at age 12-23 months had received all basic vaccinations) (Percentage)							
Children aged 6-23 months who received minimum acceptable diet (Percentage)		14.00	15.00	16.00	17.00	18.00	19.00
Children under age 5 for whom advice or treatment was sought for symptoms of acute respiratory infection (Percentage)		70.30	71.00	73.00	74.00	76.00	77.00

Intermediate Results Indicators by Components

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Component 1: Improving the Delivery and Utilization of Quality Essential Primary Health Care Service *(Action: This Component has been Revised)*							
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		799,590.00	1,575,900.00	2,388,400.00	3,215,900.00	4,076,400.00	4,972,800.00
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement) (CRI, Number)		399,000.00	817,000.00	1,200,000.00	1,700,000.00	2,200,000.00	2,700,000.00
Number of children immunized (CRI, Number)		72,412.00	145,000.00	219,000.00	294,000.00	369,000.00	445,000.00

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Number of women and children who have received basic nutrition services (CRI, Number)		668,603.00	1,310,900.00	1,985,400.00	2,669,900.00	3,384,400.00	4,129,800.00
Number of deliveries attended by skilled health personnel (CRI, Number)		58,575.00	120,000.00	184,000.00	252,000.00	323,000.00	398,000.00
Pregnant women coming for antenatal care in the first trimester (Number)		23,216.00	46,000.00	69,000.00	92,000.00	116,000.00	139,000.00
Delivery by cesarean section (Percentage)		3.70	5.00	6.00	7.00	7.00	7.00
People enrolled in the NHIS (Number)		0.00	10,000.00	50,000.00	160,000.00	260,000.00	330,000.00
Timely processing of claims submitted by health facilities to the NHIA (Percentage)		0.00	10.00	20.00	30.00	40.00	50.00
New acceptors of modern contraception (Number)		80,909.00	125,000.00	165,000.00	200,000.00	240,000.00	280,000.00
Children under 5 treated for moderate or severe acute malnutrition (Number)		2,587.00	3,900.00	5,400.00	6,900.00	8,400.00	9,800.00
Children age 12-59 months dewormed (Number)		180,402.00	260,000.00	350,000.00	400,000.00	450,000.00	500,000.00
Children between the age of 6 and 59 months receiving Vitamin A supplementation (Number)		234,243.00	480,000.00	738,000.00	1,009,000.00	1,294,000.00	1,593,000.00
Post-partum mothers supplemented with vitamin A (Number)		55,658.00	111,000.00	166,000.00	222,000.00	278,000.00	333,000.00

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Pregnant women receiving iron and folic acid (IFA) supplements (Number)		286,914.00	586,000.00	901,000.00	1,232,000.00	1,579,000.00	1,944,000.00
Health facilities reporting no stock-out of essential tracer medicines and medical supplies at the time of the health facility quality of care assessment (Number)		75.00	78.00	82.00	86.00	88.00	90.00
Health facilities that can perform diagnostic services at the time of the health facility quality of care assessment (Percentage)		10.50	15.00	25.00	35.00	40.00	50.00
Quarterly counter verification of health facility service delivery data conducted and report available (Text)		Not available as of July 31, 2020 for the April-June 2020 quarter	Counter verification report available	Counter verification report available	Counter verification report available	Counter verification report available	Counter verification report available
Timely submission of health facilities monthly reports (Percentage)		69.80	72.00	75.00	80.00	85.00	90.00
Completeness of health facilities monthly reports (Percentage)		75.70	80.00	82.00	85.00	87.00	92.00
Service delivery reports from community health workers integrated into HMIS (Percentage)		80.60	82.00	84.00	86.00	88.00	90.00
Electronic human resource management information system established (Text)		No web-based electronic human resource management information system					Web-based electronic human resource management information system established

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Electronic logistic management information system established (Text)		Web-based electronic logistic management information system					Web-based electronic logistic management information system established
Action: This indicator is New							
Health personnel trained (Number)		0.00	40.00	120.00	180.00	230.00	250.00
Births registered (Number)		101,515.00	213,000.00	336,000.00	471,000.00	619,000.00	783,000.00
Marriages registered (Number)		490.00	1,419.00	2,300.00	3,300.00	4,400.00	5,500.00
Action: This indicator has been Revised							
Health facilities renovated/constructed (Number)		0.00	0.00	0.00	2.00	3.00	10.00
Action: This indicator has been Revised							
National emergency treatment center intensive care unit, emergency observation and treatment center, public health laboratory and training center, blood transfusion center constructed (Number)		0.00	0.00	0.00	0.00	0.00	1.00

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Action: This indicator is New							
National blood transfusion center constructed (Text)		No national blood transfusion center		Architectural drawings completed	Construction initiated		National blood transfusion center constructed
Action: This indicator has been Marked for Deletion							
Health facilities renovated/constructed with energy efficient systems in place and/or with energy-efficient appliances installed (Number)		0.00	0.00	0.00	0.00	10.00	13.00
Action: This indicator is New							
Grievances addressed within stipulated service standards for response (Percentage)		0.00	10.00	40.00	50.00	70.00	90.00
Action: This indicator has been Revised							

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Health Facility Quality Index	The index, on a scale of 0 to 100, is computed for all health centers based on a quality of care assessment	Annual	Administer quality of care checklist	Quality of care checklist	Ministry of Health Directorate of Planning and Information

	checklist and the average score reported.				
Essential health services coverage index (Geometric means of tracer indicators, on a scale of 0-100)	Geometric means of six tracer indicators, on a scale of 0-100. The Geometric Mean formula in Excel is =GEOMEAN(A1:A6) (i.e., geometric mean of the data in cells A1 to A6)	2021 NCD survey/2022 Malaria Indicator Survey/2023 MICS/2025 DHS	Household survey	Nationally representative sampling	MOH DPI
Contraceptive prevalence rate	Numerator: Number of currently married women who use any modern method of contraceptive nationally *100 Denominator: Number of currently married women ages 15-49 nationally in the same period	2021 NCD survey/2022 Malaria Indicator Survey/2023 MICS/2025 DHS	Household survey	Nationally representative sampling	MOH DPI
Antenatal care, four or more visits	Numerator: Number of women aged 15 to 49 years with a live birth that received antenatal care four or more times * 100 Denominator: Number of women aged 15 to 49 years with a live birth nationally in the same period	2021 NCD survey/2022 Malaria Indicator Survey/2023 MICS/2025 DHS	Household survey	Nationally representative sampling	MOH DPI
Delivery in a health facility	Numerator: Number of deliveries in health facilities nationally *100 Denominator: Number of	2021 NCD survey/2022 Malaria Indicator	Household survey	Nationally representative sampling	MOH DPI

	births in health facilities nationally in the same period	Survey/2023 MICS/2025 DHS			
Fully immunized children (percentage of children who at age 12-23 months had received all basic vaccinations)	Numerator: Number of children who at age 12-23 months had received all basic vaccinations *100 Denominator: Number of children age 12-23 months nationally in the same period Basic vaccinations are measles, and 3 doses each of DPT or pentavalent and polio vaccine	2021 NCD survey/2022 Malaria Indicator Survey/2023 MICS/2025 DHS	Household survey	Nationally representative sampling	MOH DPI
Children aged 6-23 months who received minimum acceptable diet	Numerator: Number of children aged 6-23 months who received minimum acceptable diet *100 Denominator: Number of children aged 6-23 months nationally in the same period The minimum acceptable diet for breastfed children aged 6-23 months is defined as receiving the minimum dietary diversity and the minimum meal	2021 NCD survey/2022 Malaria Indicator Survey/2023 MICS/2025 DHS	Household survey	Nationally representative sampling	MOH DPI

	frequency, while for non-breastfed children it further requires at least two milk feedings and that the minimum dietary diversity is achieved without counting milk feeds.				
Children under age 5 for whom advice or treatment was sought for symptoms of acute respiratory infection	Numerator: Number of children under age 5 for whom advice or treatment was sought for acute respiratory infection from the following sources: public sector, private medical sector, shop, market, and itinerant drug seller *100 Denominator: Number of children under age 5 who experienced the following in the 2 weeks preceding the survey: a cough accompanied by short, rapid breathing or difficulty breathing as a result of a chest-related problem (symptoms of an acute respiratory infection) nationally in the same period	2021 NCD survey/2022 Malaria Indicator Survey/2023 MICS/2025 DHS	Household survey	Nationally representative sampling	MOH DPI

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
People who have received essential health, nutrition, and population (HNP) services		Annual	DHIS2	Annual HMIS reports	MOH DPI
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)		Annual	DHIS2	Annual HMIS reports	MOH DPI
Number of children immunized		Annual	DHIS2	Annual HMIS reports	MOH DPI
Number of women and children who have received basic nutrition services		Annual	DHIS2	Annual HMIS reports	MOH DPI
Number of deliveries attended by skilled health personnel		Annual	DHIS2	Annual HMIS reports	MOH DPI
Pregnant women coming for antenatal care in the first trimester	Cumulative number of pregnant women who received their first antenatal care in the first trimester	Annual	DHIS2	Annual HMIS reports	MoH DPI
Delivery by cesarean section	Numerator: Number of deliveries by cesarean section *100 Denominator: Number of live births nationally in the same period	2021 NCD survey/2022 Malaria Indicator Survey/2023 MICS/2025 DHS	Household survey	Nationally representative sampling	MOH DPI

People enrolled in the NHIS	Cumulative number of people enrolled in the NHIS (cumulative)	Annual	NHIS administrative data	Annual membership reports	NHIA
Timely processing of claims submitted by health facilities to the NHIA	Numerator: Number of claims submitted by health facilities to the NHIA that were processed in one month *100 Denominator: Number of claims submitted by health facilities to the NHIA in the same period	Annual	NHIS administ rative data	Annual claims processing reports	NHIA
New acceptors of modern contraception	Cumulative number of new acceptors of modern contraception (cumulative)	Annual	DHIS 2	Annual HMIS reports	MOH DPI
Children under 5 treated for moderate or severe acute malnutrition	Cumulative number of children under age 5 years treated for moderate or severe acute malnutrition	Annual	DHIS 2	Annual HMIS reports	MOH DPI
Children age 12-59 months dewormed	Cumulative number of children age 12-59 months who were dewormed	Annual	DHIS 2	Annual HMIS reports	MOH DPI
Children between the age of 6 and 59 months receiving Vitamin A supplementation	Cumulative number of children between the age of 6 and 59 months receiving Vitamin A supplementation	Annual	DHIS2	Annual HMIS reports	MOH DPI
Post-partum mothers supplemented with vitamin A	umulative number of post-partum mothers	Annual	DHIS2	Annual HMIS reports	MOH DPI

	supplemented with vitamin A (cumulative)				
Pregnant women receiving iron and folic acid (IFA) supplements	Cumulative number of pregnant women receiving iron and folic acid (IFA) supplements	Annual	DHIS2	Annual HMIS reports	MOH DPI
Health facilities reporting no stock-out of essential tracer medicines and medical supplies at the time of the health facility quality of care assessment	Numerator: Number of health facilities reporting no stock-out of essential tracer medicines and medical supplies (magnesium sulphate, amoxicillin, oxytocin, paracetamol, mebendazole, Depo-Provera injection, vitamin A, Sulphadoxine + Pyrimethamine, Tenofovir/Lamivudine/Efavirenz, Rifampin/isoniazid/pyrazinamide/ethambutol (RHZE), and Ready-to-Use Therapeutic Food (RUTF)) at the time of the health facility quality of care assessment *100 Denominator: Number of health facilities assessed in the same period	Annual	Administer quality of care checklist	Quality of care checklist	MOH DPI
Health facilities that can perform diagnostic services at the time of the	Numerator: Number of health facilities that can	Annual	Administer Quality of	Quality of Care Checklist	MOH DPI

health facility quality of care assessment	perform diagnostic services (12 core tests include: hemoglobin, blood glucose, malaria diagnostic capacity, urine dipstick- protein, urine dipstick- glucose, HIV diagnostic capacity, Dried Blood Spot collection, TB microscopy, syphilis rapid diagnostic test, general microscopy, urine pregnancy test, alanine aminotransferase (ALT) test, and creatinine) at the time of the health facility quality of care assessment *100 Denominator: Number of health facilities assessed in the same period		Care Checklist		
Quarterly counter verification of health facility service delivery data conducted and report available	Quarterly counter verification of health facility service delivery data has been conducted by the MOH M&E unit and the report is available	Annual	M&E administrative records	Annual M&E administrative records	MOH DPI
Timely submission of health facilities monthly reports	Numerator: Number of public health facilities monthly reports submitted by health facilities to the DHIS2 not later than 10th day after the end of each	Annual	DHIS2 database	Review of DHIS2 records	MOH DPI

	calendar month*100 Denominator: Number of public health facilities in the same period The GFATM equivalent indicator is Timeliness of facility reporting: Percentage of submitted facility monthly reports (for the reporting period) that are received on time per the national guidelines.				
Completeness of health facilities monthly reports	Numerator: Number of public health facilities monthly reports submitted by health facilities to the DHIS2 not later than 30th day after the end of each calendar month*100 Denominator: Number of public health facilities in the same period The GFATM equivalent indicator is Percentage of expected facility monthly reports (for the reporting period) that are actually received	Annual	DHIS2 database	Review of DHIS2 records	MOH DPI
Service delivery reports from community health workers integrated into HMIS	Numerator: Number of service delivery reports from community health workers integrated into	Annual	DHIS2 database	Review of DHIS2 records	MOH DPI

	HMIS during the last quarter of the calendar year Denominator: Number of service delivery reports from community health workers expected during the last quarter of the calendar year. GFATM indicator				
Electronic human resource management information system established	Web-based electronic human resource management information system established	Annual	National human resource for health administrative records	Annual national human resource for health administrative records	Directorate of human resource for health
Electronic logistic management information system established	Web-based electronic logistic management information system established	Annual	National Pharmaceutical Services administrative records	Annual National Pharmaceutical Services administrative records	Directorate of National Pharmaceutical Services
Health personnel trained	Cumulative number of health personnel trained	Annual	National human resource for health administrative records	Annual national human resource for health administrative records	Directorate of human resource for health
Births registered	Cumulative number of births registered by the	Annual	MOH CRVS division	Annual birth records	MOH DPI

	MOH, cumulative		administrative data		
Marriages registered	Cumulative number of marriages registered by the MOH, cumulative	Annual	MOH CRVS division administrative data	Annual marriage records	MOH DPI
Health facilities renovated/constructed	Renovation/construction of health facilities financed by the project The proposed list of facilities/structures to be considered for this indicator are: Basse District Hospital, Brikama Ba Health Center, Brikama District Hospital, Bwiam General Hospital, National emergency treatment center intensive care unit, national emergency observation and treatment center, national public health laboratory and training center, national blood transfusion center, conference center, Neonatal unit at Edward Francis Small Teaching Hospital, Bansang General Hospital staff quarters,	Annual	Maintenance unit administr ative	Annual maintenance unit administrative records	MOH DPI

	Bansang Regional Health Directorate office and staff quarters, Bansang School for Enrolled Nurses and Midwives, Farafenni Old Health Center, Kaur Health Center, Kiang Karantaba Health Center, Kudang Health Center and staff quarters, Mansa Konko staff quarters, North Bank East Regional Health Directorate office and staff quarters, and Yorro Bawol staff quarters				
National emergency treatment center intensive care unit, emergency observation and treatment center, public health laboratory and training center, blood transfusion center constructed	National emergency treatment center intensive care unit, emergency observation and treatment center, national public health laboratory and training center, national blood transfusion center, and conference center constructed	Annual	Maintenance unit administr ative records	Annual maintenance unit administrative records	MOH DPI
National blood transfusion center constructed	National blood transfusion center constructed	Annual	Maintenance unit administr ative records	Annual maintenance unit administrative records	MOH DPI
Health facilities renovated/constructed with energy efficient systems in place and/or with energy-efficient appliances	Health facilities renovated/constructed with energy efficient	Annual	Maintenance unit administr ative	Annual maintenance unit administrative records	MOH DPI

installed	systems in place and/or with energy-efficient appliances installed financed by the project The proposed list of facilities are: Basse District Hospital, Birkama Ba Health Center, Brikama District Hospital, Bwiam General Hospital, National emergency treatment center intensive care unit, national emergency observation and treatment center, national public health laboratory and training center, national blood transfusion center, conference center, Neonatal ward at Edward Francis Small Teaching Hospital, Bansang General Hospital staff quarters, Bansang Regional Health Directorate office and staff quarters, Bansang School for Enrolled Nurses and Midwives, Farafenni Old Health Center, Kaur Health Center, Kiang Karantaba Health Center, Kudang				

	Health Center and staff quarters, Mansa Konko staff quarters, North Bank East Regional Health Directorate office and staff quarters, and Yorro Bawol staff quarters				
Grievances addressed within stipulated service standards for response	Numerator is number of grievances addressed within 7 working days; denominator is number of grievances reported to MOH	Every 6 months	MOH directorate of health promotion and education ad ministrative records	Records kept by MOH directorate of health promotion and education on grievances	MOH directorate of health promotion and education

ANNEX 1: ECONOMIC AND FINANCIAL ANALYSIS

1. **The economic impact of both the parent project and the proposed AF was estimated using a CBA based on available information.** Broadly, the project benefits are estimated by evaluating the potential impact of the costs incurred on the RBF, rollout of the proposed NHIS, new and renovated health facilities on Gambians' health status measured in terms of DALYs.[13] This CBA supersedes the CBA in the parent project.

2. Although the project closes on August 29, 2025, the investments are expected to have lasting impact long after the implementation period, so the analysis considers the period spanning 2021-2031. Benefits from the parent project will accrue initially, while the impact of the proposed AF will be felt a little later. This is because the AF focuses on capital investments- constructing a fully equipped multipurpose health facility and renovating and equipping some existing facilities. Health infrastructure such as the new and renovated facilities have a long lifespan (10-20 years) and can be expected to serve their intended purposes long after the project is closed. In the long term, it is expected that the project, particularly the proposed AF will contribute to strengthening the resilience of The Gambia's health system to better respond to the ongoing COVID-19 pandemic as well as future public health emergencies.

3. The costs include the funds provided by the World Bank, GFATM and GoTG (US$86.5 million) to be disbursed according to an estimated schedule. Cost will also be incurred in operating and running the health facilities. The analysis uses the US$2.0 million GoTG counterpart funding as a proxy for the annual cost to be incurred for operating the new and renovated facilities.

4. Benefits of the AF were estimated based on the number of DALYs averted. To estimate the number of DALYs averted, the DALYs profile of The Gambia was employed (Figure A1). Although the project/proposed AF will improve all health services, this analysis assumes that the project will only have an impact on five selected causes DALYs (proxies related to the services expected to be delivered by the parent project/proposed AF), which account for 44 percent of total DALYs in The Gambia. They include maternal and neonatal morbidity, respiratory infections (including tuberculosis), enteric infections, HIV/AIDS and sexually transmitted infections, and nutritional deficiencies. The health services expected to be provided through the entire project could be critical to avoid deaths and disabilities. It is therefore assumed that the project investments will help reduce the DALYs related to these health problems in the country by 10 percent in the base case scenario. To assess the sensitivity of the results to this key assumption, DALY reductions of 15 and 5 percent are applied as well.

5. Each DALY averted is valued at gross domestic product (GDP) per capita (US$787, World Development Indicators, 2020) although the Disease Control Priorities Project[14] and Copenhagen Consensus[15] guidelines consider three-times the per capita income as a conservative estimate. After considering the effect of inflation, the real value of DALYs averted, investment, and recurrent costs are discounted at a rate of six percent, which is double the three percent suggested by the WHO.[16]

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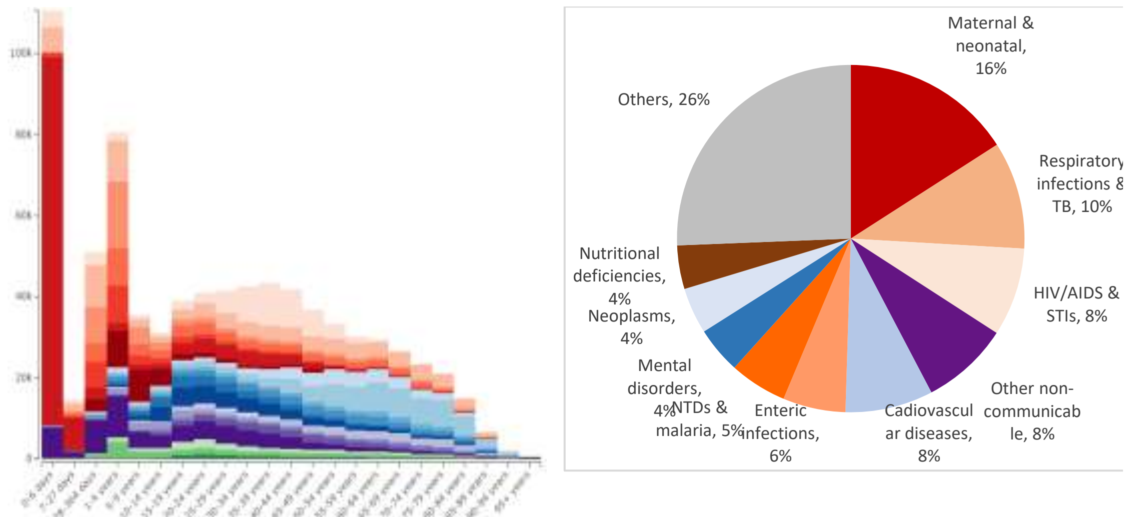
[13] DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences (WHO).
[14] The Disease Control Priority Project is an ongoing project that aims to establish priorities for disease control across the world.
[15] *Copenhagen Consensus 2008. Malnutrition and Hunger. Challenge Paper.*
[16] World Health Organization. Making Choices in Health: *WHO Guide to Cost-Effectiveness Analysis.2003*.

Figure A1: DALYs Profile in The Gambia, 2019



Source: *http://ihmeuw.org/5lpt*

6. The full range of the combined benefits of the parent project/proposed AF is expected to start in 2023 once the construction is completed and the new and renovated facilities begin operating. The project interventions, including the new and renovated health facilities will bring a significant increase in the benefits and operating costs. The combined DALYs produced from the five selected conditions were 351,055 DALYs in 2019.[17] This analysis assumes that under the high-case scenario, services provided through project interventions and the facilities will reduce the DALYs by 15 percent (52,658 DALYs)[18] annually. Key indicators of the project are expected to drive the DALY reductions. For instance, skilled attendance at delivery is estimated to avert about 16 to 33 percent[19] of all maternal deaths by preventing obstetric complications. Similarly, vaccinations, in many low-income countries, are the main point of contact for monitoring newborns' health and detecting conditions such as malnutrition.[20] An increased utilization of newborn child and infant immunization and nutrition services are expected to reduce child and infant morbidity and mortality. Again, rollout of the NHIS is likely to offer some protection against out-of-pocket expenditure, making it possible for relatively poorer households to invest in their health[21]. Quality improvements and the newly renovated and/or constructed facilities are likely to result in increased utilization of services thereby driving down DALYs.

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[17] Institute for Health Metrics and Evaluation (IHME). GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington, 2019. Available from http:// vizhub.healthdata.org/gbd-compare. (Accessed October 23 5, 2021).
[18] It is pro-rated for 2022 as the construction and renovation works will be ongoing.
[19] Graham, W., J. Bell, and C. Bullough. 2001. "Can Skilled Attendance at Delivery Reduce Maternal Mortality in Developing Countries?" page 97–130. In Safe Motherhood Strategies: A Review of the Evidence. Studies in Health Services Organisation and Policy, 17.
[20] Karing, A. (2018). Social Signaling and Childhood Immunization: A Field Experiment in Sierra Leone. University of California, Berkeley. *https://economics.yale.edu/sites/default/files/jmp_socialsignaling.pdf* (Accessed on October,28 2021)
[21] The Gambia PER (June 2020)

7. As noted above, the value of each DALY averted is US$787 (GDP per capita). The number of DALYs averted per year is multiplied by the per capita GDP to monetize the benefits due to DALYs averted. The monetary value is then discounted at a rate of 6 percent.

8. In the high case scenario, the NPV of the entire project is US$196.55 million, and its IRR is 95.15 percent, which exceeds the discount rate used in this analysis. Additionally, the NPV remains positive even when the impact on DALYs averted is reduced to 10 and 5 percent respectively (Table A1). The results show that the project/proposed AF activities will be economically viable. It is worth noting that benefits to be derived from the new and renovated health facilities are underestimated as revenues to be generated from the operations of the facilities are not factored into the calculations.

Table A1: Project NPV and IRR

	15.0% reduction of DALYs*	Sensitivity Analysis	
		10.0% reduction of DALYs	5.0% reduction of DALYs
NPV (US$ million)	196.55	102.70	8.84
IRR (%)	95.15	48.62	9.68

Note: (*) This refers to a reduction of DALYs related to maternal and neonatal morbidity, respiratory infections and TB, enteric infections, HIV/AIDS and STIs and nutritional deficiencies.