

PROJECT INFORMATION DOCUMENT (PID) CONCEPT STAGE

Report No.: PIDC871

Project Name	Maternal and Child Nutrition and Health Results Project (P143650)
Region	AFRICA
Country	Gambia, The
Sector(s)	Health (60%), Other social services (40%)
Theme(s)	Health system performance (25%), Nutrition and food security (35%), Child health (20%), Population and reproductive health (20%)
Lending Instrument	Specific Investment Loan
Project ID	P143650
Borrower(s)	The Government of the Gambia, The Government of the Gambia
Implementing Agency	National Nutrition Agency (NaNA)
Environmental Category	B-Partial Assessment
Date PID Prepared/ Updated	26-Mar-2013
Date PID Approved/ Disclosed	31-Mar-2013
Estimated Date of Appraisal Completion	00000000
Estimated Date of Board Approval	27-Feb-2014
Concept Review Decision	

I. Introduction and Context

Country Context

The Gambia is a small country in West Africa with a population of approximately 1.8 million (2011). The population has been growing at a fairly high rate of 2.8 percent per year over the last decade. The Gambia is a low income country with average per capita Gross National Income (GNI) estimated at US\$610 (2011) which is half of the sub-Saharan African average of US\$1,255. The 2011 Human Development Index shows the country at rank 168 out of 187 countries. Life expectancy at birth for the average Gambian is 58 years.

Poverty in The Gambia is pervasive in spite of a noticeable decline of overall poverty rates during the last decade. The overall poverty head count index is estimated at 48.4 percent (upper poverty line: US\$1.25 a day), down from an estimated 58.0 percent. The Gambia has had strong economic performance in recent years with an average annual real GDP growth rate of 6-7 percent during 2005-2010. However, economic growth in The Gambia – no matter how impressive – has not been

inclusive. There are large regional variations of poverty within The Gambia, with rural areas recording a substantially higher poverty head count (73.9 percent) compared with urban areas (32.7 percent).

Given a relatively undiversified economy, the country remains highly vulnerable to external shocks, with heavy dependence on rain-fed crops for agricultural production, imports for food security, and tourism receipts and remittances for foreign exchange earnings. The 2011-2012 Sahel drought caused big losses in agricultural crop production, with related impacts on household food security and nutrition, the availability of seeds for the following agriculture season, and the balance of payments.

Sectoral and Institutional Context

The Gambia's performance on MDGs 1c, 4 and 5 has been mixed. While better off than the sub-Saharan African average for under-five mortality rate (U5MR) and maternal mortality ratio (MMR), when compared to sub-regional peers like Ghana and Senegal, The Gambia's performance is lagging behind. U5MR and MMR have declined since 1990, but the progress has been modest with no indication that the country will meet MDG 4 or 5 by 2015.

Maternal health indicators continue to perform poorly. Total fertility rate (TFR) is high at 4.9 children per woman and contraceptive prevalence rate (CPR) low at only 13% (MICS 2000, 2005/6, 2010). The percentage of women who had skilled attendance at delivery – 57% – has remained largely unchanged since 2000. While at least one antenatal care (ANC) visit is nearly universal, the recommended four visits were completed by only 72% of women in 2010 (MICS 2010). Moreover, most women do not have their first ANC in the first trimester, jeopardizing healthy outcomes for both mother and child. The 2011 Maternal and Perinatal Audit of Queen Victoria Hospital highlighted delayed access to referral services by pregnant women as a major contributing factor to high maternal mortality. Furthermore, teenage pregnancies are common, resulting in a high adolescent fertility rate of 118 per 1,000 and nearly 20% of adolescent girls age 15-19 having begun childbearing (MICS 2010). Pregnancy in adolescence raises the risk for maternal mortality, morbidity and child mal-nutrition. Utilization of health services by youths is low and few facilities offer youth-friendly reproductive health services. Unmet need for family planning is estimated at 22 percent.

The Gambia requires significant efforts to make progress on undernutrition. Stunting increased between 2000 and 2005 from 24% to 28% before settling in at 27% in 2011. Furthermore, the percentage of children suffering from stunting varied by socioeconomic wellbeing with those in the poorest quintiles faring worst. Wasting declined marginally between 2000 and 2005 before increasing to 10% in 2011. The percentage of underweight children actually increased steadily between 2000 and 2011. The lagging performance on nutrition indicators is compounded by an ongoing food crisis in the Sahel region; to achieve meaningful progress in this area, high-impact community-based interventions for nutritional outcomes at both the household and community levels are critical.

In response to the lagging performance on nutrition outcomes, the World Bank and the Government of The Gambia agreed in December 2009 on a non-lending technical assistance (NLTA) with the objective to strengthen the institutional, organizational and financial capacity to improve the nutritional status of the Gambian people. The two-year NLTA was implemented by the National Nutrition Agency (NaNA) and aimed at strengthening the link between NaNA's institutional

capacity and effective implementation of nutrition policies in the Gambia. The NLTA was structured around three components: (i) Institutional reform and strengthening; (ii) Information generation, learning and communication; and (iii) Financial management and sustainable resource mobilization. The milestone by which the objective was to be measured was the elaboration of a Strategic Business Plan for Nutrition. To that effect, NaNA finalized and validated the new National Nutrition Policy 2010-2020 (NNP); elaborated and costed the Strategic Plan for Nutrition 2011-2015 (SPN); and produced the Nutrition Business Plan (NBP).

RBF) mechanism with a focus on preventive and primary care for health and nutrition was noted as a strategic step that could contribute to improving the maternal and child health and nutrition outcomes in The Gambia. Strategic factors that favor the introduction of RBF to enhance community nutrition and PHC include: (i) the renewed interest in the Ministry of Health and Social Welfare (MOHSW), with support from UNFPA, WHO and UNICEF, to scale-up the PHC service delivery system, including the village health system, and accelerate roll-out of prioritized high-impact nutrition interventions; (ii) the financing gap for high impact maternal and child health and nutrition interventions outlined in the recently completed Investment Case for Health 2013 to 2015 and Business Plan for Better Nutrition 2011-2015; and (iii) the visibility of the mother and Baby Friendly Community Initiative (BFCI) managed by the National Nutrition Agency (NaNA) under the Office of the Vice President who is also Minister of Women Affairs.

Relationship to CAS

The proposed project builds on the first Joint Assistance Strategy (JAS) 2008-2011 and is an integral part of the second Joint Partnership Strategy (JPS) 2013- 2016. The revised outcome under the Joint Assistance Strategy (JAS) 2008-2011 was a “Strengthened policy framework for nutritional programs.” Progress towards this outcome has been satisfactory. A new Nutritional Policy (2010-2020) has been formulated and validated in January 2011 and a costed Strategic Plan for Nutrition (2011-2015) has been elaborated. The Government of The Gambia implemented a two year “Technical Assistance Project” to strengthen the National Nutrition Agency’s (NaNA) capacity to improve nutrition outcomes (December 2009) alongside a “Rapid Response Nutrition Security Improvement Project,” (US\$ 3.0 million) in response to the potential negative impact of the financial crises of 2009-2009. Under pillar II of the second Joint Partnership Strategy (JPS) on strengthening the institutional capacity for economic management and public service delivery, the World Bank envisages to continue to support the sector with a combined IDA/TF operation that will focus on community-based nutrition and primary health care services for maternal and child health and nutrition. The proposed operation will use Results-Based Financing (RBF) as an innovative approach to enhance performance on maternal and child health and nutrition outcome indicators by stimulating demand, supply and quality of key health and nutrition services.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

A. Proposed Development Objective

The development objective of the project is to increase the utilization of community nutrition and primary maternal and child health care services. The proposed project is expected to contribute to the improvement of maternal and child nutrition and health outcomes

Key Results (From PCN)

This project will focus on social and behavior change at the community level and basic health

service delivery at the primary health care level. The proposed performance indicators are:

- Percentage of pregnant women receiving a 90 days supply of iron supplements;
- Proportion of pregnant women attending antenatal care in the first trimester;
- Proportion of women using a modern method of contraception;
- Proportion of mothers practicing exclusive breastfeeding for the first six months;
- Number of households engaged in fruits, vegetables and small livestock production for improved dietary quality.

Index of quality for health care services (based on a RBF checklist)

During preparation, the task team will work with the implementing agencies and coordinate with development partners to: (i) build the results framework for the continued monitoring of implementation progress and project outcomes; and (ii) develop a plan for the enhancement of M and E capacity.

III. Preliminary Description

Concept Description

Introducing a Results-Based Financing (RBF) mechanism with a focus on preventive and primary care for health and nutrition has been noted as a strategic step that could contribute to improved maternal and child health and nutrition outcomes in The Gambia. RBF measures will be identified following a results-based management approach that starts with the identification of the result to be achieved, an analysis of the bottlenecks to achieve the result, and the identification of the (RBF) measures to overcome the bottlenecks in the most efficient manner. Table 3 shows how this will work for four different results related to maternal and child nutrition and health.

The project will have three main components:

1. Community mobilization for social and behavior change;
2. Enhancing delivery of selected community nutrition and primary health care services; and
3. Capacity building for results-based management in health and nutrition service delivery.

Components 1 and 2 will apply results-based financing mechanisms to address demand- and supply-side issues as well as social and behavioral issues for improving maternal and child health and nutrition outcomes, respectively. Component 3 will strengthen overall management capacity (including M&E) of communities, local government and the health system to effectively engage in results-based management. The project will be implemented in the regions with the worst health and nutrition indicators, i.e., Central River Region (Kuntaur and Janjanbureh LGA), Upper River Region (Bassa LGA), North Bank Region (Kerewan LGA), and Lower River Region (Mansa Konko LGA). These regions together represent approximately 45 percent of the total population, or 800,000 people including 100,000 children under five and 220,000 women aged 15-59 years.

The proposed program will incentivize communities and health care providers to improve household practices as well as quality and accessibility of health services. Both communities and health care providers will receive performance-based bonuses according to their achievements on specific indicators. The proposed project uses several innovative approaches, which can be summarized as: (i) using RBF to improve nutrition outcomes in addition to maternal and child health; (ii) using RBF to promote and incentivize community-based service delivery and behavior change communication; (iii) including demand-side indicators to enhance timely utilization of health services; and (iv) allowing for the possibility build linkages with multisectoral actions for maternal and child health. Overall, the project design will look as follows:

Component 1: Community mobilization for social and behavior change • Conditional mother - baby friendly community awards • Performance/Results-based payments for community action

Component 2: Enhancing delivery of selected community nutrition and PHC services • Performance-based payments to service providers • Start up support

Component 3: Capacity building for service delivery and results-based • RBF governance and program management at national and decentralized levels • Community mobilization and organization

Component 1: Community Mobilization for Social and Behavior Change (IDA \$1 million; HRITF \$1.5 million): Component 1 will focus on community-based promotion of key family practices (i.e., the 12 family and community practices that promote child survival, growth and development) and health care seeking behaviors for improved maternal and child health and nutrition outcomes. Communities will be mobilized to implement and adhere to a set of mother and baby friendly conditions in a similar way as Baby Friendly Hospitals have to comply with 10 criteria under the Baby Friendly Hospital Initiative (BFHI). This component will use community awards conditioned on: (i) the establishment of mother and baby friendly criteria; and (ii) the promotion of selected behaviors for the improvement of nutrition and health outcomes in young children and mothers. Community ownership is a key factor in the conditional community awards.

A second measure will involve payments to communities and/or community groups based on meeting specific targets that promote key behaviors for improved health and nutrition in women and children for which communities can be held accountable. Key behaviors include:

- (i) Family practices such as infant and young child feeding practices (timely initiation of breastfeeding, colostrum feeding, feeding on demand, exclusive breastfeeding for the first six months, timely introduction of complementary foods, diversified complementary feeding); environmental, food and corporal hygiene practices; sanitation; home-based care of sick children; and food diversification (through fruits, vegetables and small livestock production); and
- (ii) Reproductive and child health care seeking practices for pregnant women, mothers and children. These can include: early start of antenatal care consultations within the first three months of pregnancy; timely referral to care centers for delivery to increase skilled attendance at birth; adoption of family planning; and bringing of children for immunization sessions.

Component 2: Enhancing Delivery of Selected Community Nutrition and Primary Health Care Services (IDA \$1.3 million; HRITF \$2.3 million): Component 2 aims to support the delivery of selected community nutrition and primary health care services at community, primary, and, where needed, referral health care levels, and will use performance-based incentives. These incentives involve a provider payment scheme based on the delivery of prior agreed maternal and child health and nutrition services. The RHTs will engage various nutrition and health-related service providers under performance-based service delivery contracts stipulating the services they will deliver and the level of payments for each service provided. The service providers include: (i) Village Support Groups – led by the Village Health Worker – to deliver a basic package of services with a focus on maternal and child nutrition and health; (ii) Community Health Nurse (CHN) to train, supervise and support the VSGs (alone and as member of the MDFT and/or the local Health Team) and deliver priority outreach health services; (iii) local Health Teams at Health Centers to supervise CHNs and deliver a package of basic facility-based and outreach services; (iv) MDFT to train, supervise and support communities and VSGs; and (v) RHTs to supervise outputs including quality of care at the

primary and community levels and to provide support and mentoring to providers within the targeted communities. Health centers can be Government-run or private (not-for-profit). An Independent Verification Agency (IVA) will be used to counter-verify whether targets have been reached by service providers; this will be done in addition to internal verification done by CHNs, local Health Teams, MDFTs and RHTs. The payments can be used, in addition to staff bonuses, to fund, inter alia, training courses for staff, and equipment (such as vehicles, electricity, medical supplies and sanitation).

Component 3: Capacity Building for Service Delivery and Results-based Management (IDA \$0.7 million; HRITF 1.2 million): This component will support the implementing entities to set up and implement RBF (including contracting and management) as well as monitor, evaluate and document the project through: (i) long-term technical assistance; and (ii) in-service as well as on-the-job training and consulting services. It will cover the costs of the IVA, the community surveys by the IVA and CBOs, the aggregation of results, the analysis of the data to monitor trends in coverage of services in project districts, and the communication and dissemination of information to all the stakeholders. This component will support essential improvement to the community nutrition and health data management systems to enable the roll-out of the RBF mechanism.

The RBF program will be designed to enable learning through process and impact evaluations to capture the effect and efficiency of the program on health and nutrition outcomes, ownership, cost-effectiveness, and other aspects of community mobilization and health system strengthening. The rolling out of process evaluations will be a key feature of the project to strengthen the learning from the RBF experience. The evaluation approach is still under discussion and will be finalized during preparation and pre-appraisal.

IV. Safeguard Policies that might apply

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

V. Financing (in USD Million)

Total Project Cost:	8.00	Total Bank Financing:	3.00
Total Cofinancing:		Financing Gap:	0.00
Financing Source		Amount	
BORROWER/RECIPIENT		0.00	

International Development Association (IDA)	3.00
Health Results-based Financing	5.00
Total	8.00

VI. Contact point

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