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Report No: PAD3939

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED GRANT

IN THE AMOUNT OF SDR 21.2 MILLION
(US$30.0 MILLION EQUIVALENT)

AND A

PROPOSED GRANT
IN THE AMOUNT OF US$5.0 MILLION
FROM THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS, AND MALARIA

TO THE

REPUBLIC OF THE GAMBIA

FOR THE

ESSENTIAL HEALTH SERVICES STRENGTHENING PROJECT

September 17, 2020

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

CURRENCY EQUIVALENTS

(Exchange Rate Effective August 31, 2020)

Currency Unit =	Gambia Dalasi (GMD)
GMD 48.13 =	US$1
SDR 0.705 =	US$1

FISCAL YEAR
January 1–December 31

ABBREVIATIONS AND ACRONYMS

BCR	Benefit-cost Ratio
CERC	Contingent Emergency Response Component
COVID-19	Coronavirus Disease
CPF	Country Partnership Framework
CRB	Complaints Review Board
CRVS	Civil Registration and Vital Statistics
DA	Designated Account
DALY	Disability-adjusted Life Year
DFIL	Disbursement and Financial Information Letter
DHIS2	District Health Information Software 2
DHS	Demographic and Health Survey
DPI	Directorate of Planning and Information
ESMF	Environmental and Social Management Framework
FM	Financial Management
FY	Fiscal Year
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GNHP	The Gambia National Health Policy
GNHSP	The Gambia National Health Strategic Plan
GPN	General Procurement Notice
GPPA	The Gambia Public Procurement Authority
GRS	Grievance Redress Service
HCI	Human Capital Index
HCW	Health Care Waste
HMIS	Health Management Information System
ICT	Information and Communication Technology
IFR	Interim Financial Report
IMF	International Monetary Fund
IPSAS	International Public-Sector Accounting Standards
IRR	Internal Rate of Return
IT	Information Technology

M&E	Monitoring and Evaluation
MCNHRP	Maternal and Child Nutrition and Health Results Project
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoFEA	Ministry of Finance and Economic Affairs
MoH	Ministry of Health
MoU	Memorandum of Understanding
NaNA	National Nutrition Agency
NCD	Noncommunicable Disease
NDP	National Development Plan
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NPV	Net Present Value
NSC	National Steering Committee
PIC	Project Implementation Committee
PCU	Projects Coordination Unit
PDO	Project Development Objective
PER	Public Expenditure Review
PFM	Public Financial Management
PHC	Primary Health Care
POM	Project Operational Manual
PPSD	Project Procurement Strategy for Development
RBF	Results-based Financing
SBCC	Social and Behavior Change Communication
SDR	Special Drawing Rights
SoE	Statement of Expenditure
SOP	Standard Operating Procedure
STEP	Systematic Tracking of Exchanges in Procurement
UHC	Universal Health Coverage
UN	United Nations
UNDB	United Nations Development Business
UNICEF	United Nations Children's Fund
VHS	Village Health Service
VHW	Village Health Worker
WASH	Water, Sanitation, and Hygiene
WBG	World Bank Group
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Gambia, The	The Gambia Essential Health Services Strengthening Project	
Project ID	**Financing Instrument**	**Environmental and Social Risk Classification**
P173287	Investment Project Financing	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 Enhanced Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date
09-Oct-2020	29-Aug-2025

Bank/IFC Collaboration

No

Proposed Development Objective(s)

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

Components

Component Name	Cost (US$, millions)

Component 1. Improving the Delivery and Utilization of Quality Essential Primary Health Care Services	32.00
Component 2. Project management	3.00
Component 3. Contingent Emergency Response Component (CERC)	0.00

Organizations

Borrower:	The Gambia
Implementing Agency:	Ministry of Health

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	35.00
Total Financing	35.00
of which IBRD/IDA	30.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	30.00
IDA Grant	30.00

Non-World Bank Group Financing

Other Sources	5.00
Foreign Multilateral Institutions (unidentified)	5.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Gambia, The	0.00	30.00	0.00	30.00
National PBA	0.00	30.00	0.00	30.00
Total	**0.00**	**30.00**	**0.00**	**30.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2021	2022	2023	2024	2025	2026
Annual	3.59	5.32	8.83	7.26	4.44	0.55
Cumulative	3.59	8.92	17.75	25.01	29.45	30.00

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

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Moderate
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

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

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] 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	Not Currently Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
Cultural Heritage	Not Currently 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).

Legal Covenants

Sections and Description

Project Implementation Committee

Financing Agreement: Schedule 2, Section I, A, 3 (a)
One month after effectiveness with respect to the establishment of the Project Implementation Committee, Recurrent, Continuous
The Recipient shall, [within thirty (30) days after effectiveness, establish and] maintain the Project Implementation Committee, at all times during the implementation of the Project with staffing, mandate, terms of reference and resources, satisfactory to the Association, for the purpose of carrying out its functions.

Sections and Description
Financial Management
Financing Agreement: Schedule 2, Section I, B, 2 from (a) to (d)
Once, 120 days after the Effective Date
The Recipient shall within one hundred twenty (120) days after the Effective Date:
(a) ensure the customization of the existing accounting software to include book-keeping of the Project and generate interim financial reports (IFRs);
(b) execute a memorandum of understanding with the Ministry of Finance and Economic Affairs (MoFEA) Directorate of Internal Audit to cover all projects financed by the Association;
(c) conduct training of the financial management unit within the PCU on the Association's financial management procedures; and
(d) recruitment of an external auditor under terms of reference acceptable to the Association which will include in scope the verification of the results-based financing activities.

Conditions

I. STRATEGIC CONTEXT

A. Country Context

1. **Since the democratic transition of 2017, the Government of The Gambia has taken important steps to lay the foundations for democracy and set the country on a new development path.** Following parliamentary elections in 2017, local elections were conducted in April 2018. The Government has allowed for a free press, rejoined the Commonwealth, and rebuilt relations with Senegal and International Financial Institutions (IFIs). Furthermore, it has taken critical measures to restore independence of the judiciary, strengthen the governance and operational independence of the Central Bank of The Gambia (CBG), establish a Treasury Single Account (TSA), and audit the civil service, uniformed services, and state-owned enterprises. In February 2018, the Government adopted a National Development Plan (NDP) 2018-2021 to foster more inclusive and private sector led growth with strong financial support from donors. The NDP is currently undergoing a reprioritization.

2. **More progress has been observed on the legislative framework to enhance governance, the rule of law, and human rights.** These include: (i) the publication of a draft Constitution in the National Gazette in September 2020 for the second time in preparation for a constitutional referendum planned for June 2021; (ii) sales of stolen assets identified by the Janneh Commission report of September 2019; (iii) publication of an interim report of the Truth, Reconciliation and Reparations Commission in April 2020 as a step toward the completion of the final report, expected by December 2020; (iv) the publication of the first (2019) annual report of the newly established National Human Rights Commission; and (v) an upgrade of The Gambia from the Trafficking in Persons Watch List by the US Department of State in its June 2020 report from Tier 3 to Tier 2 .

3. **Poverty incidence remains high and is associated with low endowment in human capital and assets.** Due to lack of growth in per capita income, the proportion of the population living in poverty remained unchanged between 2010 and 2015, at about 48 percent.[1] In absolute terms, however, the number of poor people grew from 0.79 million in 2010 to 0.93 million in 2015.[2] Almost 70 percent of the rural population is considered poor. Inequality has been low and stable since 2010 with a Gini coefficient of 35.9 percent. Marked improvements have been achieved in literacy, especially among the youth (15–24 years) whose literacy rates doubled from 31.8 percent in 2010 to 67.2 percent in 2015. Chronic malnutrition (stunting) affects 25 percent of children under the age of five, and non-monetary indicators of poverty linked to infrastructure, health, and nutrition illustrate that the country is lagging in relation to peers in Sub-Saharan Africa. Considerable inequities remain in access to basic facilities and services such as electricity and sanitation facilities. Jobs are predominately informal, and lack of off-farm activities in rural areas result in underemployment and outmigration among youth.

4. **Important progress has been made in restoring macroeconomic stability and reigniting growth.** Following strong performance under the 2019 International Monetary Fund (IMF) Staff-Monitored Program, with a sharp reduction in the fiscal deficit and debt relief from key plurilateral and bilateral creditors, The Gambia was able to exit from debt distress paving the way for an Enhanced Credit Facility approved by the IMF Board on March 23, 2020. The fiscal deficit was reduced from 6.1 percent of gross

[1] Measured using the national poverty line
[2] World Bank. 2020. Systematic Country Diagnostics for the Republic of The Gambia: Overcoming a No-Growth Legacy. Washington, DC: World Bank." based on the Integrated Household Survey (IHS) 2015/16

domestic product (GDP) in 2018 to 2.5 percent of GDP in 2019, supported by increased tax revenues and strong donor inflows[3]. Growth has remained robust at around 6 percent despite the fiscal adjustment and external shocks, including in the tourism sector. International reserves have been brought closer to prudential levels, interest rates have eased, and inflation has remained stable.

5. **The impacts of COVID-19 pandemic in The Gambia are expected to be severe.** Externally, the main impact will come from a reduction in tourists, particularly from Europe (its key market) and from trade disruptions. However, official remittances have reached record highs (a growth of 48 percent in the first half of the year of 2020 compared to the same period last year), bolstering international reserves. Domestically, private consumption is affected by containment measures and the recent imposition of a curfew. As a result, the GDP is projected to contract by 1.8 percent in 2020 compared to the pre-COVID projection of 6.3 percent. The fiscal deficit is projected to increase to 3.8 percent of GDP in 2020 (compared to the pre-COVID projection of 1.7 percent of GDP), financed by donor support. COVID-19 threatens livelihoods and undermines drivers of poverty reduction, including job creation and human capital accumulation. Furthermore, capacity constraints in the health sector could derail the fight against malaria, HIV and tuberculosis.

6. **In response to COVID-19, the Government quickly addressed the health emergency and has taken a series of socio-economic measures to protect livelihoods and support businesses.** The Gambia registered its first COVID-19 case on March 17, 2020 and as of September 15, 2020, 3,473 cases have been confirmed with 107 deaths. As a result, a National Response Strategy Road Map was adopted in March to ensure proper preparedness and response actions spanning health, social protection and socio-economic measures. Subsequently, on July 22, 2020, the Government secured parliamentary approval for a supplementary appropriation bill including further provisions for health, social protection and an economic stimulus package. The Government also secured additional donor support in order to scale up its disease surveillance, preparedness and response capacity.

7. **The World Bank Group (WBG), the IMF and other development partners have deployed a large array of technical and financial assistance to help mitigate the impact of the pandemic.** The World Bank approved a COVID-19 Preparedness and Response Project (P173798, US$10 million) in April 2020 in the health sector. The Social Safety Net Project (P167260, US$30 million) was restructured in June 2020 to widen the cash transfer program to 60,000 households. Global Partnership for Education funded Emergency Education COVID-19 Response Project (P174035, US$3.46 million) was approved in July 2020. The IMF approved a disbursement under the Rapid Credit Facility (RCF, SDR 15.55 million/US$21.3 million), Extended Credit Facility (ECF, SDR 35 million/US$47.1 million), and debt service relief under the Catastrophe Containment and Relief Trust (CCRT, SDR 2.1 million) in April 2020. The European Union (EU) and African Development Bank (AfDB) will disburse an additional US$19.4 million and US$7 million respectively as budget support grants in 2020. The Gambia is also participating in the Debt Service Suspension Initiative (DSSI).[4] The medium-term outlook is broadly positive with the economy expected to gradually recover, driven by a robust private consumption and rapidly growing public investment.

[3] World Bank. 2020. Macro Poverty Outlook -The Gambia, April 2020. Washington, DC: World Bank. http://pubdocs.worldbank.org/en/214601492188159621/mpo-gmb.pdf

[4] Letters have been sent to all bilateral, plurilateral and private creditors. The fiscal space that may be created by DSSI is around US$4.15 million in 2020 (0.23 percent of GDP).

B. Sectoral and Institutional Context

8. **The Gambia's health outcomes have gradually and steadily improved over the last two decades, yet the country continues to face some important challenges.** The under-five mortality rate has decreased from 167 to 58 deaths per 1,000 live births from 1990 to 2018. The prevalence of stunting among children under the age of five decreased between 2010 and 2018, from 23.4 to 19.0 percent, and wasting among children under five years also decreased, from 9.5 to 6.2 percent during this period. Life expectancy at birth has increased from 52 years in 1990 to 61 years in 2015. 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. The limited provision of emergency comprehensive obstetric and neonatal care along with the low level of delivery by cesarean section at 3.7 percent (below the recommended 5 to 15 percent) may be contributing to the high MMR despite the relatively high proportion of births attended by skilled health personnel. The Gambia has achieved a high percentage of children who are immunized, although this percentage has decreased in recent years—83.2 percent of children ages 12–23 months were fully immunized with the basic antigens in 2018, compared with 87.4 percent in 2010. The social distancing in response to the COVID-19 pandemic is affecting the provision of essential health services.

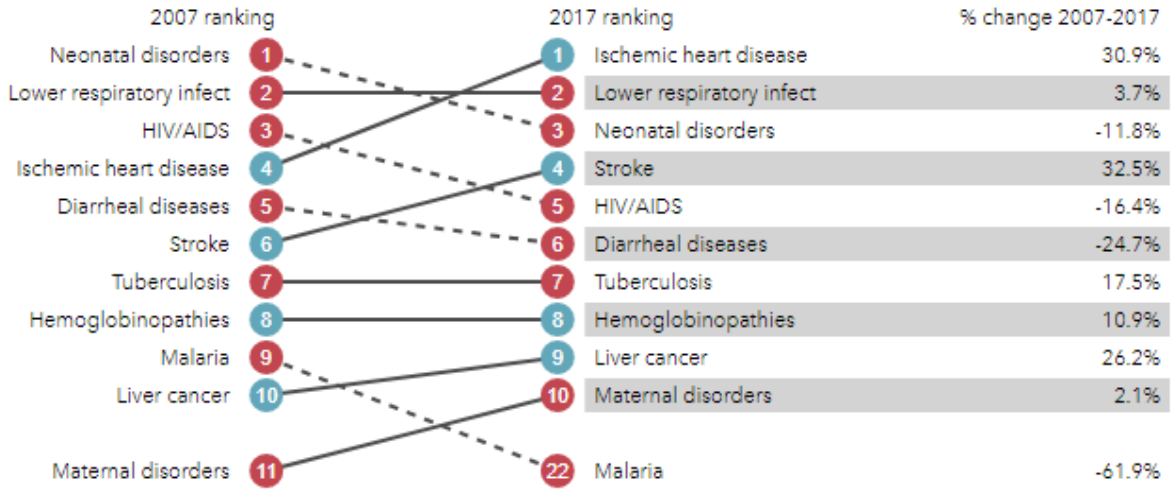
9. **Although The Gambia's Human Capital Index (HCI) score compares poorly at a global scale, it is in line with the Sub-Saharan Africa average and has demonstrated some progress in the health components.** The 2018 HCI for The Gambia is 0.40; if key health and education outcomes and trends remain constant, the cohort of Gambian children born today will achieve 40 percent of their potential productivity when they reach adulthood. The recently published 2020 HCI has shown a slight improvement with an HCI of 0.42. The HCI is a useful indicator for monitoring a country's trajectory on human capital as a core component of sustainable development. The five indicators that make up the HCI score for The Gambia are the probability of survival to age five (94 out of 100 children), a child's expected years of schooling (nine years of schooling by the 18th birthday), harmonized test scores as a measure of quality of learning (338 on a scale where 625 represents advanced attainment), adult survival rate (74 percent of 15-year-olds will survive to age 60), and the proportion of children who are not stunted (75 out of 100 children).

10. **The Gambia's progress has led to the beginning of an epidemiological transition; it currently faces a double burden of both infectious and noncommunicable diseases (NCDs) and climate change may increase the prevalence of these diseases.** Between 1990 and 2017, the burden of disease was reduced from 69,750 to 39,182 disability-adjusted life years (DALYs[5]) per 100,000 people. Infectious diseases and maternal, neonatal, and nutritional conditions remain the leading causes of premature mortality, although their proportion of the total burden has decreased during the same period, except for tuberculosis (increased by 17.5 percent), lower respiratory infections (increased by 3.7 percent),and maternal disorders (increased by 2.1 percent). In recent years, there has been a substantial increase in NCDs. For instance, between 2007 and 2017, ischemic heart disease increased by 30.9 percent and stroke by 32.5 percent (Figure 1). This is placing further pressure on the health care delivery system. NCDs contribute to higher health expenditures as they may require more expensive treatment and specially trained medical personnel. Moreover, climate change is known to increase the incidence of food and

[5] DALY, the widely used measure of overall disease burden, is sum of the years of life lost due to premature mortality in the population and the years lost due to disability for people living with the health condition or its consequences.

water-borne diseases and vector-borne diseases and alter the composition of air pollution and aeroallergen levels leading to exacerbation of symptoms for populations with preexisting health conditions such as cardiovascular and respiratory diseases.[6]

Figure 1: Primary Causes of Mortality (2017)



Source: Institute for Health Metrics and Evaluation, Retrieved June 20, 2020, from http://www.healthdata.org/gambia.

11. **The key risk factors that drive DALYs in The Gambia are intertwined with poverty and have remained consistent for the past decade**. Nutrition-related risk factors remain among the primary risk factors driving DALYs in The Gambia, which may be even more exacerbated by climate change because it affects the quantity and quality of food produced. Around 19 percent of children are stunted (24.1 percent among the poorest and 13.0 percent among the richest wealth quintile; 17.0 percent for urban dwellers and 22.0 percent for rural dwellers), and 6 percent suffer from wasting, reducing the probability of survival to age five years. Stunting and deficiencies of iodine and iron can contribute to children not reaching their developmental potential; deficiencies in zinc and vitamin A can result in the child's death. Air pollution, including household air pollution, which is caused by indoor burning of solid fuels, is the second most important risk factor to DALYs lost, leading to increased rates of respiratory illnesses. Water, sanitation, and hygiene (WASH)-related risk factors have decreased from second ranking in 2007 to third in 2017, which is still substantial.

12. **The Gambia has observed rapid population growth that has increased pressure on the economy and national health system.** The annual population growth rate is estimated at 2.9 percent, making it one of the highest in the world, because of the continued high fertility rate (4.4 births per woman in 2018), including the fertility rate among adolescents. Early marriage is a major risk factor to the high fertility rate, increasing unplanned pregnancies and total unwanted fertility and contribute to the high MMR. The Gambia's high fertility rate poses significant challenges to the national health system making it more difficult to offer quality health services. The lack of knowledge, awareness, and acceptance of modern contraceptive methods are also major impediments leading to low usage by women who are currently married or in union (16.3 percent). Further, the civil registration and vital statistics (CRVS) system is

[6] Prüss-Ustün, A. et al. 2019. "Environmental Risks and Non-communicable Diseases." *BMJ* 364: 17–19.

currently paper based and the related law (1990 Births, Deaths, and Marriages Registration Act) needs to be updated. A robust electronic CRVS system that can capture up-to-date, reliable data on the occurrence of births, deaths, marriages, and divorces in the country can provide the 'denominator' for estimating health services coverage rates at the national and subnational levels. The WBG supported the development of a CRVS Strategic Improvement Plan, which was finalized in July 2018. Additionally, the digitization of paper birth registers has been undertaken in six of seven regions and indexing of the digital images is under way and will be linked to the data collection exercise for the proposed social registry.[7] A desk review of the 1990 Births, Deaths, and Marriages Registration Act has been completed and the process for its amendment has been initiated.

13. **The Gambia's health care delivery system is three tiered with an abundance of health care facilities that are unevenly distributed.** There are approximately 1,019 health care facilities (Table 1) mostly located in the Central River Region due to the high number of village health services (VHSs). Each tier refers patients to the next higher tier of services. The primary tier consists of VHSs and community clinics for promotive and preventive health care. The VHSs are staffed by village health workers (VHWs) and community birth companions. The community clinics are run by community health nurses or midwives. The secondary tier includes minor and major health centers that serve as referral facilities for the first tier. Minor health centers provide core health services, including basic emergency obstetric and neonatal care; when cases are beyond their capacity, they refer patients to major health centers. Major health centers carry out minor surgeries and provide comprehensive emergency obstetric care and radiology and laboratory services, among others. Hospitals comprise the tertiary level of care; the highest-level referral facility is the teaching hospital in Banjul, the capital city. The formal private health care sector is concentrated in the Greater Banjul area, and is much smaller relative to the public health sector. While almost all of the nurses and environmental health officers who are working in The Gambia are graduates of its health care training institutions, less than 10 percent of the doctors are Gambians. The Ministry of Health (MoH) recruits large number of Cuban doctors to fill the vacancies.

Table 1: Health Facilities by Type and Region, The Gambia, March 2020

Tier	Heath Care Facilities	WR1	WR2	NBW	NBE	LRR	CRR	URR	Total
1	VHSs	29	116	116	127	115	278	110	891
	Community clinics	3	25	5	4	9	11	11	68
2	Minor health centers	10	4	5	6	6	6	8	45
	Major health centers	1	1	0	0	1	1	1	5
3	District hospitals	0	1	1	0	1	0	1	4
	General hospitals	2	1	0	1	0	1	0	5
	Teaching hospital	1	0	0	0	0	0	0	1
Total		46	148	127	138	132	297	131	1,019

Source: January–December 2019 Gambia District Health Information Software 2 (DHIS2).
Note: WR1 = Western Region 1; WR2 = Western Region 2; NBW = North Bank West; NBE = North Bank East; LRR = Lower River Region; CRR = Central River Region; and URR = Upper River Region.

14. **There is a need to strengthen primary health care (PHC) services in The Gambia.** High-quality PHC is globally recognized as a key driving force for advancing universal health coverage (UHC) and the 2030 Sustainable Development Goals Agenda. In The Gambia, minor health centers deliver up to 70

[7] The Gambia Social Safety Net Project (P167260), which was approved by the WBG, in the amount of US$30 million, in May 2019, includes the development of a social registry. The Government has endorsed the proposed integration of the social registry and CRVS and the use of the CRVSNOW Platform.

percent of the basic health care package, including basic emergency obstetric care. There is a significant imbalance between allocations to hospitals (third tier, Table 1) and PHC (first and second tier), 43 percent compared to 9 percent of the total health budget in 2018. Spending on primary care will be of utmost importance if The Gambia is to improve productivity of its human capital.

15. **Most health care facilities are in dilapidated condition and are poorly equipped to produce standard quality of care.** According to a 2019 service availability and readiness assessment study conducted by the United Nations Children's Fund (UNICEF), less than half (46 percent) of the 109 facilities assessed had all the basic equipment—blood pressure apparatus, stethoscope, thermometer, adult scale, child scale, and light source—to deliver basic health services. Stock-out data are not readily available to help track geographic access to supplies and build accountability among supply chain stakeholders. Further, there is no national blood transfusion center to enable the safe handling, screening, and processing of blood. Health care waste (HCW) management continues to remain a challenge particularly in two regions not supported by the WBG-financed Maternal and Child Nutrition and Health Results Project (MCNHRP) (P143650).

16. **The US$10 million WBG-financed The Gambia COVID-19 Preparedness and Response Project (P173798) supports the Government of The Gambia's National Response Strategy Road Map for COVID-19 in the health sector[8].** The Government is scaling-up its disease surveillance, preparedness and response capacity to ensure COVID-19 does not undermine the progress that has been made in human capital development in The Gambia. The COVID-19 Preparedness and Response Project has enabled swift actions to be taken and a summary of the activities financed under the Project is shown in Box 1.

Box 1. Gambia COVID-19 Preparedness and Response Project Activities

Component 1: Emergency COVID-19 Response

The activities that this component has financed so far include:

- Establishment of media center and enhancement of the call center;
- Procurement of equipment and furniture for the Public Health Emergency Operations Center;
- Procurement of Ecosteryl HCW treatment machines for the establishment of clinical waste treatment centers;
- Production and installation of billboards and production and distribution of posters;

Component 2: Strengthening Multi-sector, National Institutions and Platforms for Policy Development. The activities that this component has financed so far include procurement of information technology (IT) equipment for the Public Health Emergency Operations Center and e-surveillance.

Component 3: Supporting National and Sub-National Prevention and Preparedness

The activities that this component has financed so far include:

- Procurement of motorbikes, pickup trucks, and cargo truck for community engagement and delivery of supplies;
- Procurement of laboratory equipment and supplies, reagents, and test kits;
- Procurement of medical equipment and supplies, and ambulances;
- Renovation of treatment centers; and
- Preparatory work for the proposed construction of national emergency treatment center and national public health laboratory and training center.

Component 4: Implementation Management and Monitoring and Evaluation

[8] The Gambia's National Response Strategy Road Map also includes other sectors such as: (i) social protection headed by the Vice President and co-led by the National Nutrition Agency; (ii) the socio-economic impact led by the MoFEA; and (iii) Rule of Law headed by the Ministry of Justice.

17. **There are significant constraints to the effectiveness, efficiency, and equity of public health expenditures in The Gambia that have led to inefficiencies in service delivery**. According to the 2019 Public Expenditure Review (PER) undertaken by the WBG in collaboration with the Government, The Gambia spends less on health compared with Sub-Saharan Africa countries that have the same HCI. The general government expenditures on health as a percentage of GDP is only 0.82 percent (lower than the low-income countries' average of 1.31 percent). In comparison, Burkina Faso spends 2.71 percent, Lesotho 5.15 percent, Rwanda 2.29 percent, and Burundi 1.80 percent. Several issues were identified, which include inequitable access to and use of quality health services; little or no financial protection for the poor; a significant imbalance in allocations to primary, secondary, and tertiary health care; a weak fiduciary management system; highly centralized budget management systems leading to delays in execution; and weak budget information management systems. The PER recommends an increase in the budgetary allocation to the MoH, financial risk protection against catastrophic health expenditures prioritizing the poor, decentralization of the budget management system, strengthened fiduciary management systems, increased allocation for PHC, prioritization of PHC in delivering the essential health care package, and implementation of a robust expenditure management information system. The PER was limited by paucity of expenditure data and inadequate heath information system data.

18. **The Gambia MCNHRP (P143650), which closed on June 30, 2020, has contributed to improved health service utilization and quality of care**. The implementation of the Results-based Financing (RBF) activities which was undertaken by the National Nutrition Agency (NaNA) was successful and led to a greater uptake in health service utilization and contributed to achieving tremendous improvement in the quality of care in the 37 project-supported health facilities in the five project regions. As a result of the high disbursement, the MCNHRP was previously scheduled to close on July 31, 2021, and was restructured in March 2019 to close on June 30, 2020. Almost all the July 2021 end line targets of the intermediate results indicators in the results framework were surpassed. For instance, as of September 30, 2019, the 115,843 deliveries attended by skilled health personnel had surpassed the June 2020 target of 95,000 and the 59,856 pregnant women who received their first antenatal care in the first trimester were three times the June 2020 target of 20,000.

19. **The implementation of the RBF sustainability road map started in September 2018 helped transition the RBF program from NaNA to the MoH.** The MoH, Ministry of Finance and Economic Affairs (MoFEA), and NaNA jointly developed an RBF sustainability road map in September 2018, which proposed a national RBF institutional framework with details on institutional sustainability, financial sustainability, and operational sustainability. Regarding financial sustainability, the MoH and MoFEA have demonstrated commitment to RBF by allocating GMD 12 million (about US$250,000) and GMD 40 million (about US$800,000) of the 2019 and 2020 government budget, respectively.

20. **Government policies and strategies in the health sector are geared toward UHC** by ensuring that everyone has access to quality essential health care services without creating financial hardship. Both The Gambia National Health Policy (GNHP) (2012–2020) and The Gambia National Health Strategic Plan (GNHSP) (2014–2020), which are expiring this year, aim to accelerate provision of quality services and UHC. The MoH has initiated the process for developing a GNHSP for 2021–2025 and a GNHP for 2021–2030. Further, The Gambia NDP (2018–2021) calls for the establishment of a social health insurance scheme, as a drive toward UHC. According to The Gambia Multiple Indicator Cluster Survey (MICS) 2018,[9] only about 2.4 percent of women and 3.9 percent of men ages 15–49 years had health insurance, of whom

[9] The Gambia Bureau of Statistics. 2019. *The Gambia Multiple Indicator Cluster Survey 2018, Survey Findings Report*. Banjul.

93.2 and 92.6 percent, respectively, obtained health insurance through an employer. However, a large portion of the working population in the country is engaged in the informal sector, signifying the need for arrangements for financial protection against catastrophic out-of-pocket costs of health care.

21. **On September 3, 2020, the National Health Insurance Scheme (NHIS) Bill, which establishes the NHIS, was approved by the Cabinet, gazetted and submitted to the National Assembly.** The WBG provided technical guidance to the NHIS Steering Committee to draft the NHIS Bill. Both MoH and MoFEA are committed to passing the bill when the regular sessions resume. Subsequently, the national health insurance authority (NHIA) will be established to finalize a suite of regulations and NHIS operational manuals. Moreover, US$2 million of the 2020 government budget has been allocated to the NHIS. A World Bank-financed actuary study is being finalized on projections of the costs and revenues of the national health budget (including the implementation of the proposed NHIS) over a decade to assess the potential financial impact of introducing NHIS on the health budget. An essential health care package for the various levels of the health care system (VHSs, community clinics, minor and major health centers, general/district hospitals, and the teaching hospital) is being finalized. It will feed into the development of standards for infrastructure and equipment and for updating the essential medicines lit, quality-of-care checklists, and staffing norms for the various levels of the public health care system as well as for the private health facilities. The benefit package for the health insurance scheme will be derived from the essential health care package.

C. Relevance to Higher Level Objectives

22. **The proposed project is in line with WBG's Country Engagement Note (Report No. 123654) for FY18–FY21 which has improving nutrition and PHC as the main focus areas.** The May 2020 Systematic Country Diagnostics (Report No. 148128-GM), which will feed into the forthcoming Country Partnership Framework (CPF) for FY22-FY25 highlighted that inadequate access to and quality of health services undermine inclusive growth at all stages of the life cycle. The project aims to build on the success of the MCNHRP (P143650) and continue to improve the quality of health services. Moreover, the WBG is fully committed to support the Government with its COVID-19 response and has adjusted the country program in line with pillars of the WBG COVID-19 Crisis Response Approach Paper *Saving Lives, Scaling-up Impact and Getting Back on Track*. Accordingly, the proposed Project will build on the ongoing COVID-19 Preparedness and Response Project (P17378) to strengthen the health system and improve the utilization of essential health services.

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

23. The Project Development Objective (PDO) *is to improve quality and utilization of essential health services in The Gambia.*

PDO Level Indicators

24. The two PDO-level results indicators are the following:

(a) **Health facility quality index (percentage).** The index, on a scale of 0 to 100, is computed for all health centers based on a quality-of-care assessment checklist and the average score reported. Baseline value will be computed for the June 2020 assessment.

(b) **Essential health services coverage index (percentage).** Geometric mean of six tracer indicators, on a scale of 0 to 100. The baseline was 45.90 percent based on the 2019-2020 DHS data.[10]

(i) Contraceptive prevalence rate (percentage) was 17.1 percent in 2019-2020

(ii) Antenatal care, four or more visits (percentage) was 78.5 percent in 2019-2020

(iii) Delivery in a health facility (percentage) was 83.7 percent in 2019-2020

(iv) Fully immunized children (percentage of children who at ages 12–23 months had received all basic vaccinations) were 84.6 percent in 2019-2020

(v) Children ages 6–23 months who received minimum acceptable diet[11] (percentage) were 14.0 percent in 2019-2020

(vi) Children under age 5 for whom advice or treatment was sought for symptoms of acute respiratory infection (percentage) were 70.3 percent in 2019-2020

B. Project Components

25. The proposed project will support the implementation of the 2021–2025 GNHSP and has three components.

Component 1. Improving the Delivery and Utilization of Quality Essential PHC Services (US$32 million equivalent: US$27 million IDA and US$5 million from Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM))

26. This component has three subcomponents, as described below:

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

27. The proposed 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: (i) provision of performance-based financing (PBF) grants to health facilities for the delivery of the newly defined essential health care package; (ii) support to verification of the quality of services; and (iii) enhancing capacity for the expansion of RBF nationally. The limited maternal and child

[10] Formula in Excel is = GEOMEAN (A1:A6), that is, geometric mean of the data in cells A1 to A6.
[11] The minimum acceptable diet for breastfed children ages 6–23 months is defined as receiving the minimum dietary diversity and the minimum meal frequency, while for non-breastfed children it further requires at least two milk feedings and the minimum dietary diversity is achieved without counting milk feeds.

health and nutrition services covered in the MCNHRP (P143650) will gradually be expanded to include other services in the essential health care package such as integrated management of neonatal and childhood illnesses, infectious diseases, NCDs, and emergency obstetric care. However, the geographical coverage will remain the same as for the MCNHRP i.e. the five rural regions (with 40 percent of the population).

28. As stipulated in the NHIS Bill, the proposed 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 MoH will ensure a smooth transition. Since 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 to lay the ground and ensure smooth transition for the implementation of the NHIS payment mechanisms. In the event the NHIS Bill is not being 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.

29. 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 an essential PHC package. A national RBF operational manual has been updated and incorporated in the Project Operational Manual (POM).

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

30. The activities proposed in this subcomponent aim to scale-up and expand the Social and Behavior Change Communication (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 resolve 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$21 million: US$16 million IDA and US$5 million GFATM)

31. This subcomponent will support MoH's efforts to building resilient and sustainable health systems to support the delivery of quality health services and for strengthening CRVS. The GFATM has allocated US$5 million, as part of a parallel Co-Financing arrangement with the World Bank,[12] to support designated health systems strengthening thematic areas such as Health Management Information System (HMIS),

[12] The Co-financing deadline for the effectiveness of the Co-financing agreement between the Gambia and GFATM is December 31, 2020. In the highly unlikely event that the Co-financing agreement between the Gambia and GFATM does not materialize, the results framework will be modified through restructuring or additional financing from IDA, if such resources may be available.

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 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. This subcomponent will support provision of equipment to and renovation of selected health facilities to improve the delivery of emergency obstetric and newborn care, establishment of a national blood transfusion service, and improve HCW management. Energy-efficient measures will be put in place to reduce greenhouse gas emissions such as the procurement of energy-efficient equipment and materials for renovations[13] as well as climate-resilient materials to mitigate flood risks and climate-related emergencies.

Component 2. Project Management (US$3 million equivalent IDA)

32. The proposed project will be managed and coordinated by the MoH PCU including financial management (FM) and procurement, M&E, environmental and social 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.

Component 3. Contingent Emergency Response Component (CERC)

33. This component enables the rapid reallocation of project proceeds in the event of a natural or man-made disaster or crisis that has caused or is likely to imminently cause a major adverse economic and/or social impact. A detailed CERC operational manual has been developed and included in the POM.

C. Project Beneficiaries

34. The expected project beneficiaries will be the population at large given the national coverage of the package of essential health care services at each level of the health care delivery system and the health personnel who will be trained.

D. Results Chain

Problem Statement

35. Low quality and low utilization of essential health services, along with poor coverage of health insurance, have resulted in limited progress toward achieving UHC in The Gambia.

Problems and Constraints

- Low quality of care at health facilities
- Low utilization of essential health services

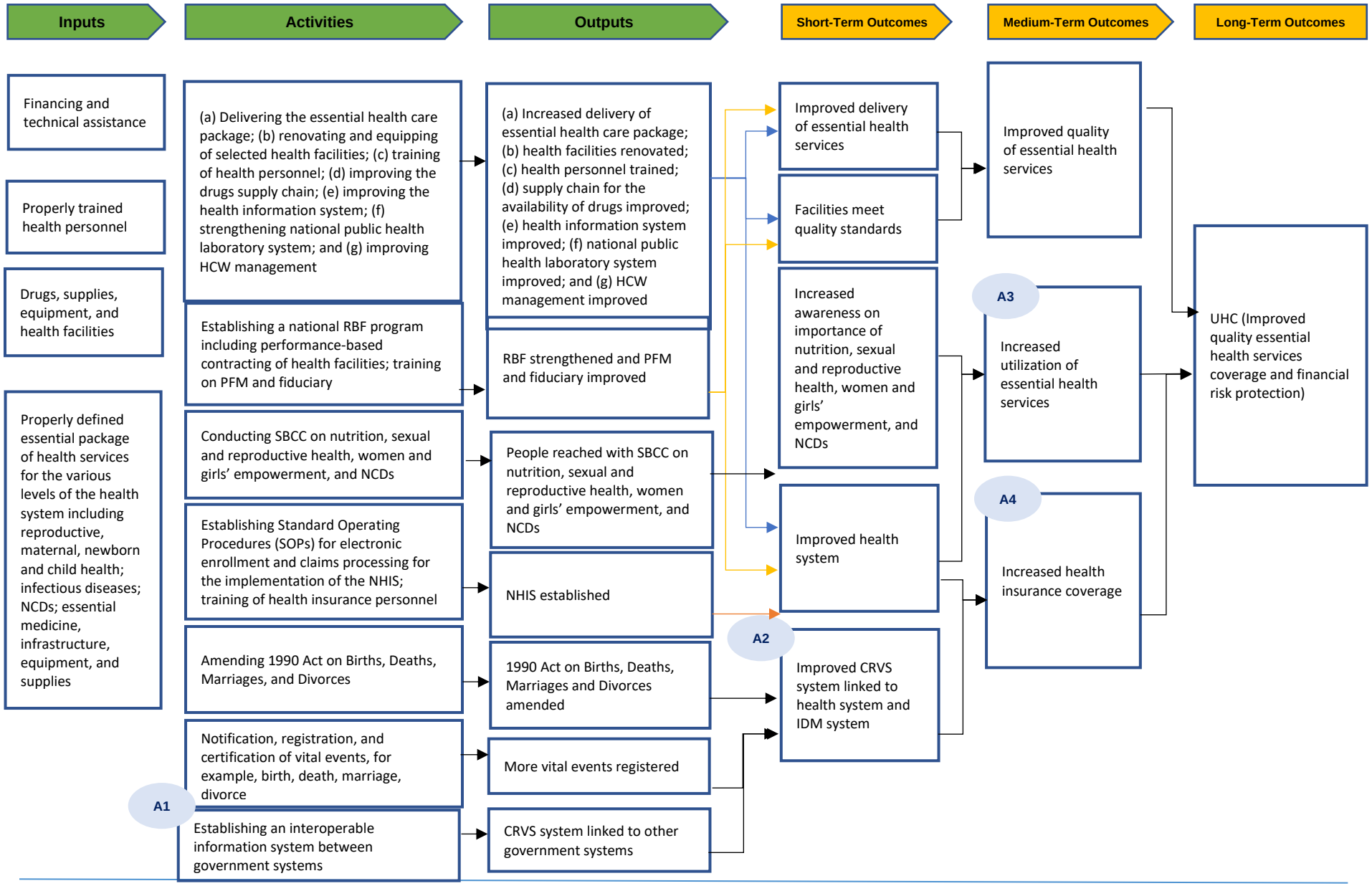
[13] These can include energy-efficient features such as efficient ventilation systems, temperature and humidity controls, low-energy lighting, energy-efficient and low-carbon construction material, and use of modern and efficient water supply and treatment.

- Dilapidated physical infrastructure and inadequate equipment at health facilities
- Frequent stockouts of essential medicines and supplies at health facilities
- Weak national public health laboratory system
- Weak public financial management ([PFM] budget development and implementation) and fiduciary (FM and procurement) systems
- High out-of-pocket expenditure for health
- Limited understanding of the determinants of strong health outcomes, especially for the following areas:
    - Nutrition
    - Sexual and reproductive health
    - Women and girls' empowerment
    - NCDs
- Inadequate number and distribution of properly trained skilled health personnel
- Lack of timely and accurate data for evidence-based decision-making and monitoring of programs at subnational levels
- Low registration of births, deaths, marriages, and divorces and lack of a robust CRVS system that can provide data for the 'denominator' for estimating health services coverage rates at the national and subnational levels

Assumptions

- A1: Data will be shared while data privacy and confidentiality are protected.
- A2: Systems will be linked through unique identification numbers assigned to individuals.
- A3: Citizens will seek services when they appreciate the importance and benefits.
- A4: Improvement in the identification of individuals will lead to enrolling those individuals into the NHIS.

Figure 2: Theory of Change



E. Rationale for World Bank Involvement and Role of Partners

36. The WBG's Health, Nutrition, and Population's strategic directions for 2020–2025 prioritizes universal, high-quality, and affordable PHC as the foundation of every country's health system, particularly in fragility-, conflict-, and violence-affected countries such as The Gambia. Health financing remains low, inefficient, and inequitable in The Gambia to address these challenges in the health sector. Further, health facilities are in dilapidated conditions and poorly equipped and support from development partners for civil works is low. The WBG was the largest financier in the health sector response to COVID-19. The WBG will work alongside the MoH to improve the delivery of essential services, such as immunization and antenatal care, that are hampered by the COVID-19 pandemic.

37. There are very few development partners in the health sector in The Gambia. The majority of the funding of GFATM and Gavi are 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 but are not major financiers of health programs.

F. Lessons Learned and Reflected in the Project Design

38. **Lessons learned from the successful implementation of the RBF activities of the MCNHRP (2015–2020) have been reflected in the project design.** The MCNHRP led to a greater uptake in health service utilization, where the end line targets of the intermediate results indicators in the results framework were largely surpassed and contributed to improved quality of services. In the regions where the MCNHRP was implemented, anecdotal evidence indicated that health worker motivation was high. The MoH and MoFEA demonstrated commitment to RBF by allocating GMD 12 million (about US$250,000) of the 2019 government budget to RBF.

39. **Inclusion of an NHIS in the project design was based on lessons learned from close collaboration with the NHIS Steering Committee.** The WBG has been providing technical support to the NHIS Steering Committee since August 2019. At a special cabinet session on November 5, 2019, the Government announced that the NHIS will be initiated in 2020. The Government has allocated GMD 100 million (about US$2 million) in the 2020 budget to the NHIS.

40. **In designing the national RBF institutional framework, separation of functions was critical to avoid conflict of interest and select a cost-effective and sustainable structure.** The RBF's institutional arrangements have further been re-examined to forestall duplication of roles, responsibilities, and relationships with the NHIS implementation arrangements. The MoH senior management has appointed RBF program and deputy program managers (civil servants) and the institutional arrangements for the national RBF program have been finalized for use in the proposed project.

41. **The WBG has undertaken procurement and FM assessments of the MoH PCU.** It is contributing to enhance the fiduciary (procurement and FM) capacity of the PCU by providing hands-on training on WBG guidelines and procedures. For instance, the PCU is becoming familiar with the WBG fiduciary electronic management systems (that is, the Systematic Tracking of Exchanges in Procurement [STEP] and the WBG's Client Connection System) for procurement and FM, respectively. The PCU has managed the Government's 2019 and 2020 budgetary allocation to RBF by making payments directly to health facilities based on invoices submitted by NaNA.

42. **Findings of a health sector PER jointly carried out by the WBG health and MoH teams have been reflected in the current project.** This PER fed into a national PER led by the WBG's country economist. The findings from the PER showed significant constraints to the effectiveness, efficiency, and equity of public health expenditures. Issues identified include inequitable access to and use of quality health services; little or no financial protection for the poor; a low level of health expenditures; a significant imbalance between allocations to secondary, tertiary, and PHC; delays in the execution of the health budget; a weak fiduciary management system; highly centralized budget management systems and weak budget information management systems; and inefficient health facilities. The PER recommended an increase in the budgetary allocation to the MoH, financial risk protection against catastrophic health expenditures, decentralization of the budget management system, strengthening of fiduciary management systems, increased allocation for PHCs, and implementation of a robust expenditure management information system.

43. **Interventions that addressed the impact of external factors such as climate variability and climate change on the population during the MCNHRP (2015–2020) were also reflected in the project design.** Poor and erratic rainfall during project implementation (2014) led to a food security crisis, which could have significantly affected nutrition rates in the country. However, additional financing was provided to include interventions that would strengthen the resilience of communities and mitigate short-term economic poverty for vulnerable families. The proposed project aims to gain a better understanding of the climate and environmental risk factors to health outcomes and ensure that climate-resilient measures are put in place to enable the health sector to be better prepared to respond to climate-related emergencies.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

44. **The MoH will be responsible for the implementation of the project** with the involvement of the project implementation committee (PIC), National Steering Committee (NSC), and PCU. The institutional and implementation arrangements for the project are summarized in Figure 3.

Project Implementation Committee

45. A PIC, chaired by the Permanent Secretary and comprising the Directors of the implementing MoH directorates, RBF Unit senior staff, and PCU senior staff, will approve the annual work plans and budgets and meet monthly to discuss the annual work plan implementation progress, bottlenecks and remedial actions, ensuring that proposals and budgets are in line with the GNHSP and government rules and regulations. The MoH directorates will provide monthly activity reports to the PCU and the PCU will prepare a consolidated report for the PIC monthly meetings. The Permanent Secretary will provide regular updates to the Minister of Health. The PIC will have its first meeting in the near future to review and approve the first annual work plan and budget.

MoH Implementing Directorates

46. **The MoH directorates and units will be the implementing entities of specific project subcomponents**. The MoH Permanent Secretary will provide prompt and efficient oversight of the directorates that will be involved in project implementation, including the directorate of planning and information (DPI), directorate of health promotion and education, directorate of national pharmaceutical services, directorate of national public health laboratories, directorate of public health, directorate of human resource for health, Directorate of nursing and midwifery services, directorate of research, and office of the directorate of health services. In the current MoH Directorates, the Permanent Secretary provides oversight of the directorates and reports to the Minister of Health.

National Steering Committee

47. **The existing NSC provides strategic guidance, stewardship, and coordination for the health sector and oversees the PCU and the national RBF Unit**. The committee has a multidisciplinary, cross-government, and development partner involvement and comprises the following members: Permanent Secretary (1) of the MoH as Chairperson; Permanent Secretary (2) of the MoH as Vice Chairperson; Director of Health Services of the MoH; Coordinator of the MoH PCU as Secretary; Program Manager of the RBF Unit as Assistant Secretary; Permanent Secretary of the MoFEA; Chief Executive Officer of the NHIA; Director of Planning and Information of the MoH; Executive Director of NaNA; Director of the Department of Community Development; Development Partners (including WBG, GFATM, WHO, Gavi, and UN agencies); Executive Director of the Country Coordinating Mechanism; Action Aid International The Gambia; and a University of The Gambia representative.

48. The NSC has the following responsibilities: (a) meets quarterly to discuss progress, outputs, bottlenecks, and constraints and makes recommendations; (b) provides oversight and support for the PCU coordinator and RBF Unit program manager; (c) oversees and monitors the development of the overall strategic direction and policy framework of the RBF program in The Gambia; (d) ensures that RBF is implemented in line with objectives of the GNHP and other key documents of the Government of The Gambia; and (e) carries out advocacy and resource mobilization for the RBF Unit and the PCU.

Projects Coordination Unit

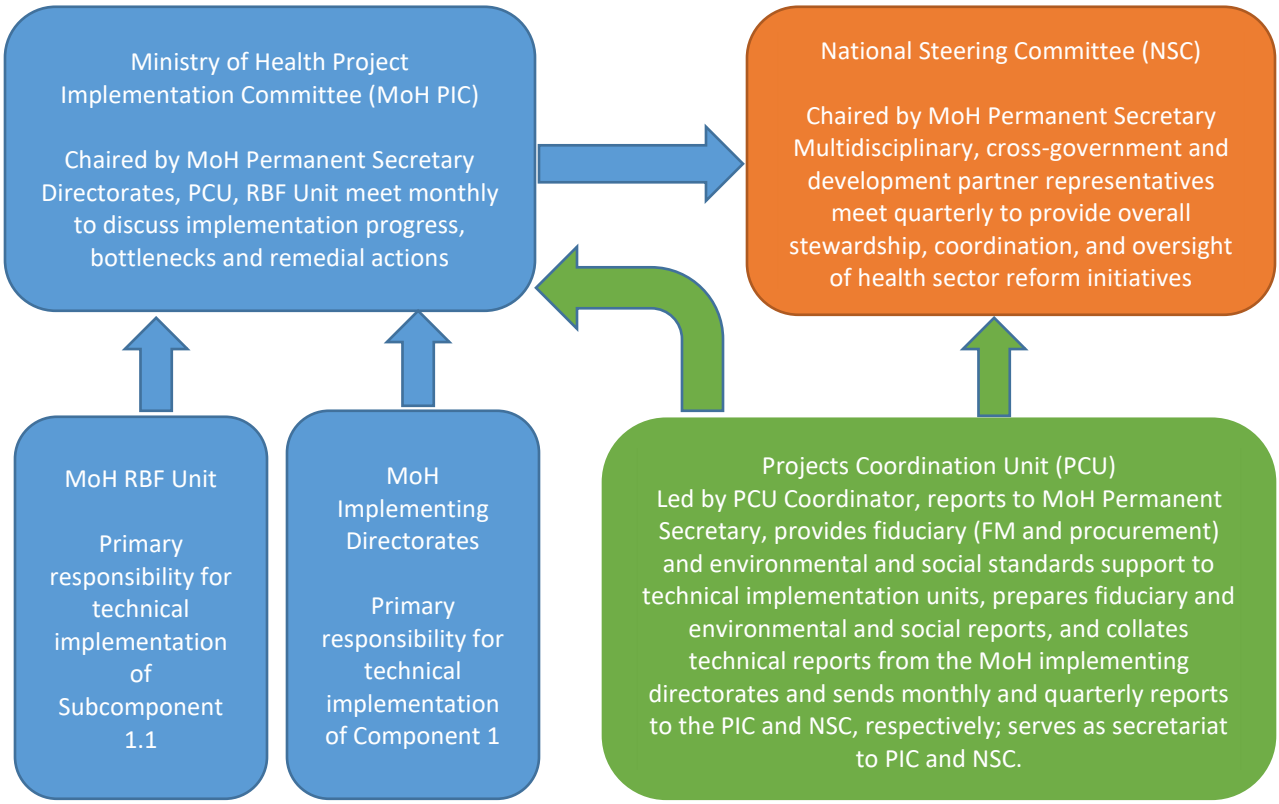
49. **The PCU was established to provide integrated and coordinated project management interventions in health-related programs**. The PCU staff currently comprise PCU Coordinator, senior operations officer, FM specialist, a senior accountant and five accountants, procurement officer and procurement assistant. The Project Coordinator reports to MoH Permanent Secretary, and the PCU manages the Project's fiduciary (FM and procurement) and environmental and social due diligence, prepares the annual work plans and budgets, prepares fiduciary and environmental and social reports, collates technical reports from the MoH implementing directorates and sends monthly and quarterly reports to the PIC and NSC, respectively. The PCU will hold its weekly meetings to review implementation progress, resolve problems, and plan accordingly. The PCU will organize monthly PIC and quarterly NSC meetings and prepare the minutes. The PCU will work closely with MoH Procurement and Accounts Units staff to facilitate skills and knowledge transfer.

50. The PCU managed the Government's 2019 and 2020 budgetary allocation to RBF by making payments directly to health facilities based on invoices submitted by NaNA. The PCU has experience working on projects financed by multilateral development partners, mainly GFATM, and The Gambia COVID-19 Preparedness and Response Project (P173798) approved on April 2, 2020, which is the first WBG-financed project the PCU has managed. The WBG has undertaken a procurement and FM assessment of the PCU and is helping enhance the fiduciary (procurement and FM) capacity of the PCU by providing hands-on training on WBG guidelines and procedures. For instance, the PCU is now familiar with the WBG fiduciary electronic management systems (that is, the STEP and the WBG's Client Connection System) for procurement and FM, respectively. Given that the PCU is familiar with the GFATM processes, it will be able to manage the co-financing arrangement between the WBG and GFATM.

Ministry of Health Results-Based Financing Unit

51. The MoH has appointed two senior civil servants, RBF Program Manager, and RBF Deputy Program Manager, to the RBF Unit to coordinate and oversee the implementation of the national RBF program. The RBF Unit will contribute to the technical implementation of Subcomponent 1.1 and will be responsible for the capacity building for the expansion of RBF nationally on purchasing and verification of services. As stipulated in the NHIS Bill, the proposed 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 MoH will ensure smooth transition.

Figure 3: Institutional Arrangements



B. Results Monitoring and Evaluation Arrangements

52. **Capacity**. The project's results framework has all the baseline values (for the PDO-level and intermediate results indicators); annual targets; and a monitoring plan for each indicator (definition of indicator, frequency of data collection, data source, methodology for data collection, and responsibility for data collection). During implementation, the PCU will liaise with the MoH M&E Unit, HMIS Unit, information and communication technology (ICT) Unit, and the NHIA to produce data for monitoring the Results Framework and prepare reports for dissemination to relevant stakeholders and for informed decision-making and course correction, where necessary. The MoH M&E Unit will manage the project M&E, and the MoH HMIS Unit will ensure quality of data. Capacity of the MoH M&E Unit, HMIS Unit, and ICT Unit will be enhanced as described in Subcomponent 1.3.

53. **Data sources**. The sources of data will be the DHIS2, MoH administrative records, MoH Quality Assurance Unit, and household survey. The process for obtaining the quality-of-care data and ensuring quality of DHIS2 data is detailed in the POM. The other data sources are administrative records, which have to be kept diligently to ensure accuracy of the data. Household survey is the data source for the essential health services coverage index and cesarean section rate. A household survey schedule will be developed, and surveys conducted. Tentatively, household survey data will be obtained from the 2019-2020 Demographic and Health Surveys (DHSs), 2021 NCD survey, 2022 Malaria Indicator Survey, 2023 MICS, and 2025 DHS.

54. **Reporting requirements and dissemination**. Various reports will be produced during project implementation and closing, including semiannual reports, annual reports, implementation status and results reports, midterm review report, and implementation completion and results report. The templates for the reports are detailed in the POM, and depending on the type of report, the sections of a report could cover progress updates according to component (achievements, challenges, and recommendations); procurement; FM; grievance redress and citizen engagement; safeguards; dissemination and data use; compliance with legal covenants; and lessons learned (positive and negative). The reports, including lessons learned, will be widely disseminated to stakeholders, including to civil society organizations and the public.

C. Sustainability

55. The Government of The Gambia's demonstrated commitment to achieving UHC increases the likely sustainability of the project. The MoH participated in the prioritization of activities and the project design. To improve institutional sustainability, the project will support enhancing the management and technical capacity of the MoH and PCU staff to implement the project. Regarding financial sustainability, since 2019 the Government of The Gambia has been allocating funds in its annual budget to RBF and also US$2 million of the 2020 government budget has been 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.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic, and Financial Analysis

56. The project's development impact, rationale for public investment, and WBG value added are summarized in the following paragraphs.

Development Impact

57. **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 2020 Gambia's HCI (estimated to be 0.42). This could be achieved through improvements in the health status of the population by reducing the MMR, 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 are expected to lead to improved health outcomes.

58. **In line with the PDO and costs associated with project interventions, a cost-benefit analysis (CBA) is carried out to determine the viability of the project.** The analysis is built around the part of the PDO focusing directly on improved utilization of essential health care services. A CBA is conducted to determine whether the dollar benefits of that component are likely to outweigh its dollar costs. The benefit-cost ratio (BCR), net present value (NPV) and internal rate of return (IRR) are the metrics used to assess the expected return on investment of Component 1. To test the robustness of the analysis, a sensitivity analysis is carried out to ascertain the effects of changes in the key parameter used in the analysis.

59. Under the base case scenario, Component 1 would yield a BCR of 2.68 (Table 2), indicating that for every dollar invested, the project would produce an economic return of US$2.68. The investment of US$27 million would generate economic benefits with a positive NPV of US$36.51 million. The IRR is 126 percent, which is substantially higher than the available 16 percent cost of capital in The Gambia.

Table 2: Results of CBA Base Case Scenario and Sensitivity Analyses

	Discount Rate (%)	NPV (US$, millions)	IRR (%)	BCR
Base case scenario	16	36.51	126	2.68
Scenario 1	10	44.51	126	2.90
Scenario 2	20	32.11	126	2.54

Public Sector Involvement

60. **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 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 professionals' practice in tertiary facilities in urban areas.[14] 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

[14] The Gambia Health PER 2019.

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 proposed project's performance-based contracting approach would help address systemic services delivery issues that might not be attractive to profit-oriented private sector.

Value Added of World Bank Group

61. **In addition to financing, the World Bank has comparative advantage in tapping into global knowledge to inform the design and implementation of the project.** The client would benefit from targeted knowledge products that focus primarily on the implementation of the results-based approach through delivery of specific technical assistance intended to build the client's capacity to effectively implement the project. There are very few development partners in the health sector in The Gambia, mainly GFATM and Gavi (with focus on specific disease programs) and UN agencies. The WBG is unique in its ability to mobilize investment financing, technical assistance, and advisory services and galvanize relevant stakeholders, including development partners in support of a multisectoral approach to contribute to improving health outcomes.

B. Fiduciary

(a) Financial Management

FM and Disbursement Arrangements

62. The FM arrangements will be based on the existing arrangements in place within the PCU. The Gambia COVID-19 Preparedness and Response Project (P173798), in the amount of US$10 million, which was approved on April 2, 2020, is the first World Bank-financed operation being implemented by the current PCU team and the PCU has good experience in implementing GFATM projects. The overall performance of the National Malaria Control Program financed by GFATM and executed by the PCU is satisfactory. Staffing has remained adequate and proper books of accounts and supporting documents have been kept. The auditor has issued an unqualified opinion on the audited financial statements from 2016 to 2018. The PCU has signed a Memorandum of Understanding (MoU) with the MoFEA Directorate of Internal Audit to cover the audit of the ongoing projects. However, a specific MoU will be signed with the MoFEA Directorate of Internal Audit for the World Bank-financed project and an internal audit report will be submitted to the World Bank on a quarterly basis. The accounting system in place is adequate and will be customized to include the bookkeeping of the project. The current FM team which consists of a financial controller, a senior accountant, and five accountants is also adequate and will be able to manage the project. However, an accountant will be dedicated to the bookkeeping of the project. The current PCU's manual of procedures is being updated in line with World Bank standards and will include the specificities of the project such as Subcomponent 1.1 on improving the quality of essential PHC services delivery using a RBF approach and included in the POM.

63. To accommodate the project in the existing FM system and ensure readiness for implementation, the POM includes an FM section in line with World Bank FM procedures and detailed procedures for requesting and reporting on Subcomponent 1.1. The following measures should also be taken no later than four month after effectiveness: (a) the customization of the existing accounting software to include

book-keeping of the project and generate interim financial reports (IFRs); (b) signing a MoU with the MoFEA Directorate of Internal Audit to cover all World Bank-financed projects; (c) training of the FM Unit on World Bank FM procedures; and (d) recruitment of an external auditor who will include in its scope the verification of the RBF activities.

(b) Procurement

64. **Procurement regulations**. Procurement under the project will be based on WB Procurement Regulations dated July 2016, revised in November 2017 and August 2018 under the New Procurement Framework (NPF), the 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants,' revised on July 1, 2016, and other provisions stipulated in the Financing Agreement. Approaches to all markets will entail use of the WBG's standard procurement documents. In addition, the WBG's STEP, which the MoH staff have already been trained on, would be used to communicate all procurement requests and information to the WBG.

65. **Procurement capacity and risk assessment.** Procurement risk is assessed as Substantial**.** A procurement capacity and risk assessment conducted by the WBG identified the following procurement risks: (a) the Country Procurement System is not fully open and competitive with a high number of Direct Contracting (63 percent) and no penalties are imposed for lack of compliance; (b) public access to procurement information is also limited (for example, contract's award and complaints decision are not published); (c) the PCU which will handle procurement activities of all projects managed by the PCU which includes the proposed project, and those of the GFATM, GAVI and UNICEF has only one procurement specialist and a procurement assistant; and (d) in accordance to section 47 of The Gambia Public Procurement Authority (GPPA) Act, the MoH contracts committee is handling procurement activities with contract values more than US$5,000 and this might cause delay in implementation.

66. To mitigate the abovementioned procurement risks, the following actions are recommended, some of which are already being implemented by the MoH:

(a) The GPPA Act has been amended and the procurement system is becoming more open and competitive. The use of the STEP will allow public access to project procurement information including contract's award and complaints decision.

(b) The full-time PCU procurement specialist and procurement assistant will continue to provide procurement support to the project during implementation and a procurement officer will be recruited to assist with the increasing workload.

(c) Procurement training has been provided to the PCU staff, including initial training during project preparation by the WBG and in-depth on-the-job procurement trainings will be provided during project implementation.

(d) Given the high volume of PCU procurement activities, the PCU will set up a contracts committee which will be chaired by the Permanent Secretary (or designee) and comprises Director of the DPI, Director of directorate of national pharmaceutical services, PCU Coordinator, PCU Financial Controller or Senior Accountant, PCU Procurement staff with PCU Procurement Specialist as Secretary, and PCU Senior Operations Officer. The committee will have the following responsibilities: (a) reviewing, verifying, and ascertaining that all

procurement and disposal have been undertaken; (b) approving the selection of the successful bid or proposal; (c) ensuring that the PCU does not pay in excess of prevailing market prices; (d) reviewing and approving aggregation of procurements, where proposed; (e) reviewing and approving the use of lots, where packaging into lots has been proposed; (f) approving the list of consultants qualified to submit proposals; (g) approving the list of suppliers/contractors to be given requests for quotations; and (h) reviewing the quarterly reports on awarded contracts.

67. **Procurement strategy and approach.** The MoH has prepared a Project Procurement Strategy for Development (PPSD) for the project with support from the WBG team. The PPSD presents how procurement activities will support the development objective of the project and deliver the best value for money under a risk-based approach. In addition, the PPSD includes the rationales for procurement decisions, including selection of the approach to market and procurement methods. The high valued procurement activities include equipping and renovating health facilities. The PPSD and the Procurement Plan of the project shall be regularly updated as appropriate during project implementation.

68. **Procurement Plan.** Based on the outcome of the PPSD, an initial Procurement Plan covering the first 18 months of project implementation has been developed and agreed upon with the Recipient. The initial Procurement Plan is available in STEP and will be updated at least annually, or as needed, to reflect the current status of implementation of each procurement activity/contract or to modify/delete or add activities/contracts. Updates of the Procurement Plan will be submitted to the WBG for its review and approval before implementation. Prior Review Contracts are subject to review by the WBG at each stage of the procurement process. Contracts below the prior review thresholds as captured in the approved Procurement Plan shall be subject to post review by the WBG team on an annual basis, in accordance with the procedures set forth in the Procurement Regulations.

C. Legal Operational Policies

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

D. Environmental and Social

69. The project will have a positive impact on improving the quality and utilization of essential health services. The overall risk classification is moderate. Five Environmental and Social Standards have been triggered, to address environmental and social risks pertaining to the civil works, the generation of HCW, and the introduction of electronic medical records and electronic CRVS system. To prepare for and mitigate against these risks, a full suite of Environmental and Social Framework instruments has been prepared.

70. A *Stakeholder Engagement Plan* was developed and has been publicly disclosed on August 7, 2020. The project will support SBCC to raise public awareness and knowledge among the general population on primary prevention activities and delivery of PHC as well as on cross-cutting issues such as nutrition, women and girls' empowerment, NCDs, WASH, and climate change. The project will coordinate

and monitor all communication interventions and material development at both the national and regional levels. The project will ensure that activities are inclusive and culturally sensitive, making sure the vulnerable groups also benefit from the project. An *Environmental and Social Commitment Plan* (ESCP), which was developed and publicly disclosed in the WBG website on August 7, 2020, sets out material measures and actions, specific documents or plans, as well as the timing for each of these, and will be monitored and reported to the WBG during implementation.

71. Regarding environmental factors, the project renovations and upgrading of health facilities have the potential to have negative impacts such as noise, dust emissions, generation of solid and liquid waste, and health and safety issues. To respond to the environmental, social, health, and safety impacts, an *Environmental and Social Management Framework* (ESMF) has been developed and publicly disclosed in the country and the WBG website on September 4, 2020, to support the environment and social due diligence provisions for activities financed by the project. It covers the Environmental and Social Management Plan and the Infection Control and Waste Management Plan. The Environmental and Social Management Plan identifies potential environmental, social, health, and safety issues associated with the renovations and operation of health care facilities. The Infection Control and Waste Management Plan focuses on infection control and HCW management practices during the operation of health care facilities. Working conditions and occupational health and safety issues pertaining to the civil works are covered in the Labor Management Procedures, prepared as part of ESMF, while risk of sexual exploitation and abuse/sexual harassment because of labor influx will be mitigated as part of the ESMF/Environmental and Social Plan provisions.

72. Strengthening CRVS will require proper data protection and privacy, which is addressed in the provisions of the Civil Registration Bill which is to be passed by Parliament. Additionally, the Information Communication Act already has some provisions on Data Protection and Privacy, but the Ministry of Information and Communication Infrastructure is leading the drafting of a comprehensive bill on Data Protection and Privacy which will be applicable to all sectors including MoH.

73. A project-level grievance redress mechanism will be established to resolve complaints and grievances of people affected by the Project in a timely, effective and efficient manner that satisfies all parties involved. It will a) provide affected people with avenues for making a complaint or resolving any dispute that may arise during the course of the implementation of the project; b) ensure that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants to avoid the need to resort to judicial proceedings. It will build on the call center established by MoH as part of COVID-19 response and include other channels such as direct contact with a health personnel, comment box at health facilities, MoH website and Facebook page.

V. GRIEVANCE REDRESS SERVICES

74. **Communities and individuals who believe that they are adversely affected by a WBG supported project may submit complaints to existing project-level grievance redress mechanisms or the WBG'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 WBG's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WBG non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the WBG's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the WBG's

corporate 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 WBG Inspection Panel, please visit www.inspectionpanel.org.

VI. KEY RISKS

75. The overall risk of the proposed operation to improve utilization and quality of essential health services in The Gambia is assessed as substantial.

76. **Political and governance risks are assessed as substantial.** The political coalition established in late 2016 after President Barrow assumed office is fragile and the next presidential elections are due to take place in 2021. The Government has shown commitment to the health sector reform agenda, particularly as it relates to the RBF approach and NHIS, and the proposed project has included mitigation measures into the design to strengthen governmental institutional capacities. The MCNHRP contributed to improving utilization and quality of health care which is in line the PDO of the proposed project.

77. **Macroeconomic risks are assessed as substantial.** 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. This risk to achieving the PDO will be mitigated by frontloading the project's allocation to Subcomponent 1.1 until the Government's allocation increases in subsequent years.

78. **Institutional capacity for implementation and sustainability risks are assessed as substantial.** The PCU had limited previous experience working on WBG operations but is implementing 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 project identification and the capacity of the MoH will be enhanced with time to become familiar with WBG procedures and policies. Further, health personnel are focused on the COVID-19 pandemic response and this has affected the delivery of essential health services. If the pandemic persists longer, it will adversely affect the implementation of the proposed project. The MoH has set up a national committee on continuity of essential services to help ensure provision of essential health services.

79. **Climate screening and co-benefits**. This project has been screened for climate change and the following vulnerabilities were identified through the process. The overall potential risks in The Gambia were assessed as 'moderate' in the Summary Climate and Disaster Risk Screening Report. The exposure rating was assessed as '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. However, the risk on project activities and outcomes is categorized as 'moderate' due to several adaptation measures that will enable health care workers, communities, and vulnerable groups to cope in the next few years and 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 greenhouse gases.

80. Mean annual temperatures have increased by 1.0°C since 1960 and is projected to increase by 1.1 to 3.1°C by the 2060s with interior regions projected to warm more rapidly than coastal areas[15]. Wet season rainfall (July – September) has decreased significantly between 1960 and 2006, at an average rate of 8.8 mm per month and it is projected to continue to decrease. However, heavy rainfall events are projected until 2090s. An increase in heat and rainfall events may lead to food insecurity, particularly impacting maternal and child health, due to the population's heavy reliance on rain-fed crops that are vulnerable to persistent drought[16]. 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 major cause of mortality in 2017. Extreme rainfall 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.

81. Under Component 1 (US$27 million), several activities will be implemented to improve adaptation measures in communities and health facilities. Analyses will be conducted on the climate risk factors of cardiovascular and respiratory mortality and on climate-resilient practices that can be adapted in communities and in health care settings. This will help inform the communication strategy that will be prepared to improve the understanding of climate change and the various adaptation measures that communities can put in place to ensure that their health is not compromised (that is, early warning systems). SBCC 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. Further, mitigation measures will be implemented such as the procurement of equipment, supplies, and renovation materials that are energy efficient. This may include 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. An assessment on the procurement of more efficient HCW management technologies to reduce pollution may also be undertaken. Infrastructure damage from extreme weather events and other climate-related emergencies can be very severe and can cause increased mortality and disabilities through injuries. Ensuring that health facilities that are being renovated are climate-resilient will be a critical aspect of this component. Assessments of health care infrastructure and its vulnerability to severe weather events such as excessive rainfall that can lead to flooding will be assessed.

[15] World Bank Climate Change Knowledge Portal. 2020. Country Profile – The Gambia. Washington, DC.
[16] 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.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY: Gambia, The

The Gambia Essential Health Services Strengthening Project

Project Development Objectives(s)

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

Project Development Objective Indicators

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		84.60	85.00	86.00	87.00	88.00	90.00

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
(percentage of children who 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							
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

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Number of children immunized (CRI, Number)		72,412.00	145,000.00	219,000.00	294,000.00	369,000.00	445,000.00
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		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	
supplemented with vitamin A (Number)							
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		No web-based electronic human resource					Web-based electronic human resource

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
system established (Text)		management information system					management information system established
Health personnel trained (Number)		0.00	40.00	120.00	180.00	230.00	250.00
Marriages registered (Number)		5,000.00	10,000.00	15,000.00	20,000.00	30,000.00	40,000.00
Births registered (Number)		101,515.00	213,000.00	336,000.00	471,000.00	619,000.00	783,000.00
Health facilities renovated (Number)		0.00	0.00	0.00	2.00	3.00	4.00
National blood transfusion center constructed (Text)		No national blood transfusion center		Architectural drawings completed	Construction initiated		National blood transfusion center constructed
Grievances responded to within stipulated service standards for response (Percentage)		0.00	10.00	20.00	30.00	40.00	50.00

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 checklist and the average score reported	Annual	Administer quality of care checklist	Quality of care checklist	Ministry of Health Directorate of Planning and Information

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 births in health facilities nationally in the same	2021 NCD survey/2022 Malaria Indicator Survey/2023 MICS/2025	Household survey	Nationally representative sampling	MOH DPI

	period	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 frequency, while for non-breastfed children it further requires	2021 NCD survey/2022 Malaria Indicator Survey/2023 MICS/2025 DHS	Household survey	Nationally representative sampling	MOH DPI

	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	Annual	NHIS administrativ	Annual membership reports	NHIA

	(cumulative)		e data		
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 adminis trative 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	Cumulative number of post-partum mothers supplemented with vitamin A (cumulative)	Annual	DHIS2	Annual HMIS reports	MOH DPI
Pregnant women receiving iron and folic acid (IFA) supplements	Cumulative number of pregnant women receiving	Annual	DHIS2	Annual HMIS reports	MOH DPI

	iron and folic acid (IFA) supplements				
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 health facility quality of care assessment	Numerator: Number of health facilities that can perform diagnostic services (12 core tests include: hemoglobin, blood glucose, malaria diagnostic capacity, urine dipstick- protein, urine	Annual	Administer Quality of Care Checklist	Quality of Care Checklist	MOH DPI

	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				
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 calendar month*100 Denominator: Number of public health facilities in the same period The GFATM equivalent	Annual	DHIS2 database	Review of DHIS2 records	MOH DPI

	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 HMIS during the last quarter of the calendar year Denominator: Number of service delivery reports from community health	Annual	DHIS2 database	Review of DHIS2 records	MOH DPI

	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
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
Marriages registered	Cumulative number of marriages registered by the MOH, cumulative	Annual	MOH CRVS division administrative data	Annual marriage records	MOH DPI
Births registered	Cumulative number of births registered by the MOH, cumulative	Annual	MOH CRVS division administrative data	Annual birth records	MOH DPI
Health facilities renovated	Renovation of health facilities financed by the project	Annual	Maintenance unit administrative	Annual maintenance unit administrative records	MOH DPI

National blood transfusion center constructed	National blood transfusion center constructed	Annual	Maintenance unit administrative records	Annual maintenance unit administrative records	MOH DPI
Grievances responded to 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 administrative records	Records kept by MOH directorate of health promotion and education on grievances	MOH directorate of health promotion and education

Some of the indicators regarding number of beneficiaries such as number of people who have received essential HNP services entail double counting since the same person can receive services multiple times over the life of the project and will be counted more than once. There is no existing unqiue identifiction number database to prevent double counting in the HMIS.

ANNEX 1: Implementation Arrangements and Support Plan

Implementation Arrangements

1. The project's institutional arrangements are described in Section III, and FM, disbursement, procurement, environmental safeguards, and social safeguards are described in Section IV of this document. Detailed manuals for FM, the PPSD, RBF, ESMF, Stakeholder Engagement Plan, and results M&E arrangements have been developed and included in the POM, which has been adopted. The implementation support plan is described in the following paragraphs and will be reviewed periodically to ensure that it continues to meet the implementation support needs of the project.

Project Institutional and Implementation Arrangements

Financial Management Arrangements

2. **Budgeting:** The project budgeting process is described in the POM. The budget would be reviewed and endorsed by the NSC, before the beginning of each fiscal year. Annual work plan and budgets would be submitted for the World Bank No Objection no later than November 30th each year before adoption and implementation. Any changes in the budget and work plans would be approved by the PIC and receive a World Bank No-Objection opinion.

3. **Accounting:** The PCU will use the cash basis to maintain the project's accounts which will be supported with appropriate records and procedures to track commitments and to safeguard assets. The project financial statements will be prepared using International Public-Sector Accounting Standards (IPSAS) considering IDA requirements and specificities related to external financed investment projects. Accounting and control procedures will be documented in the POM. The current PCU's accounting software (FINEX) will be customized within four months after project effectiveness to accommodate the book-keeping of the project. The project accounting will be managed through the existing accounting software which has multi-project and multi-donor features, it will be customized for the bookkeeping of the new project. An accountant will be recruited to the book-keeping of this project

4. **Internal control and internal auditing arrangements:** The POM will include the FM and disbursement arrangements and the internal controls mechanism, budgeting process, assets' safeguards, and clarify roles and responsibilities of all stakeholders. An MoU will be signed with the MoFEA Directorate of Internal Audit for the World Bank-financed project within four months of project effectiveness and an internal audit report will be submitted to the World Bank on a quarterly basis.

Financial Reporting Arrangements

5. The PCU will prepare quarterly unaudited IFRs reflecting operations of the designated account (DA) and submitted to the World Bank, within 45 days after the end of each calendar quarter. The IFR format would comprise the following: (i) report on the sources and use of funds by disbursement category and by component, in a cumulative basis (project-to-date; year-to-date) and for the period, showing budgeted amounts versus actual expenditures, including a variance analysis; and (ii) forecast of sources and uses of funds.

6. The PCU will also produce the projects Financial Statements and these statements will comply with the IPSAS principles and World Bank requirements. These Financial Statements will be comprised of:

- A Statement of Sources and Uses of Funds which includes all cash receipts, cash payments and cash balances;
- A Statement of Expenditures (SoE)
- Accounting Policies Adopted and Explanatory Notes
- A Management Assertion that project funds have been expended for the intended purposes as specified in the relevant Financing Agreement.

Funds Flow and Disbursement Arrangements

7. ***Disbursement methods****:* The following disbursement methods may be used under the project: reimbursement, advance, direct payment and special commitment as specified in the Disbursement and Financial Information Letter (DFIL) and in accordance with the Disbursement Guidelines for Investment Project Financing, dated February 2017. Disbursements would be **transactions based** whereby withdrawal applications will be supported with SoE. The DFIL will provide details of the disbursement methods, required documentation, DAs ceiling and minimum application size. These were also be discussed and agreed during negotiations of the Financing Agreement and DFIL.

8. ***Banking arrangements***: A DA will be opened at the Central bank of the Gambia. The PCU will open a GMD transaction account in a commercial bank for the day to day activities of the project. For the project implementation the DA will be replenished through the submission of withdrawal applications. Requests for reimbursement and reporting on the use of advances will be accompanied by a SoE providing information on payments for eligible expenditures and records required by the World Bank. All supporting documentation will be retained at the PCU and must be made available for periodic review by the World Bank's missions. The frequency of reporting of expenditures will be monthly but not greater than three months. Disbursement from the IDA grants will follow WBG procedures. Eligible expenditure will be disbursed against the following as shown in Table 1.1.

Table 1.1: Eligible Expenditures and Disbursements

Category	Amount of the Grant Allocated (expressed in SDR)	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) PBF Grants under Subcomponent 1.1 of the Project	5,000,000	100%
(2) Goods, works, non-consulting services, consulting services, Training and Operating Costs under Subcomponents 1.1, 1.2 and Component 2 of the Project	12,000,000	100%
(3) Goods, works, non-consulting services, consulting services, Training and Operating Costs under Subcomponents 1.3 of the Project	4,200,000	55%
(4) Emergency Expenditures under Component 3 of the Project	0	-
TOTAL AMOUNT	21,200,000	

9. **Disbursement deadline date.** The project will have a disbursement deadline date (final date on which the World Bank will accept applications for withdrawal from the Recipient or documentation on the use of grant proceeds already advanced by the World Bank of four months after the closing date of the project. Expenditures incurred between the closing date and the disbursement deadline date will not be eligible for disbursement. All documentation for expenditures forwarded to the World Bank for disbursements will be retained and will be made available to the external auditors, for annual audit, and to the World Bank and its representatives, if requested. In the event that auditors or the World Bank implementation support missions find that disbursements made were not justified by the supporting documentation or are ineligible, the World Bank may, at its discretion, require the Recipient to (a) refund an equivalent amount to IDA or (b) exceptionally, provide substitute documentation evidencing other eligible expenditures.

10. **Operating costs.** These are reasonable costs required for the day-to-day coordination, administration, operation, and supervision of project activities. This includes leasing and/or routine repair and maintenance of vehicles; equipment; facilities and office premises; fuel; office supplies; utilities; consumables; communication expenses (including postage, telephone, and Internet costs); operating costs of information campaigns including media costs, printing and photocopying expenses, bank charges, publications, and advertising expenses; registration cost, plate issuance fee, and insurance cost for project motor vehicles; project-related meeting expenses; project-related travel, subsistence, and lodging expenses; and other administrative costs and costs of contractual staff directly related to the project. The operating costs exclude consulting fees and salaries, or equivalent payments of members of the recipient's civil service.

Auditing Arrangements

11. The Financing Agreement will require the submission of Audited Financial Statements for the project to IDA within six months after the project closing end of the accounting period. An external auditor with qualification and experience satisfactory to the World Bank will be appointed to conduct yearly audit of the project's financial statements. A single opinion on the Audited Project Financial Statements in compliance with International Federation of Accountant (IFAC) will be required. The external auditors will also prepare a Management Letter giving observations and comments, and providing recommendations for improvements in accounting records, systems, controls and compliance with financial covenants stipulated in the Financing Agreement.

12. In accordance with World Bank Policy on Access to Information, the Recipient is required to make its audited financial statements publicly available in a manner acceptable to the World Bank; following the Word Bank's formal receipt of these statements from the Recipient, the World Bank also makes them available to the public. The external auditor would include in its scope the verification of the RBF activities.

Figure 1.1: Fund Flow

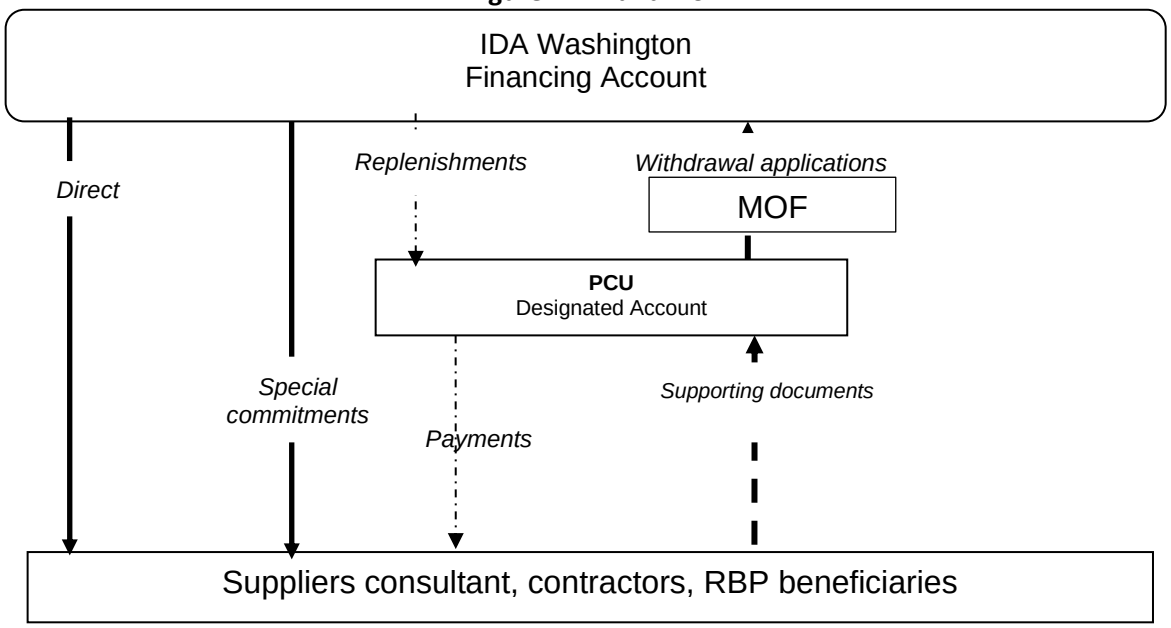


Table 1.2: FM Action Plan

No	Action	Due Date	Responsible
2	The customization of the existing accounting software to include the bookkeeping of the project	No later than four months after effectiveness	PCU
3	Sign an MoU with the MoFEA Directorate of Internal Audit to cover all World Bank-financed projects	No later than four months after effectiveness	PCU
4	Training of PCU FM staff to World Bank Procedures	No later than four months after effectiveness	PCU
5	Recruitment of an external auditor	No later than four months after effectiveness	PCU

Financial Covenants

13. Financial covenants are the standard FM requirements are covered under Section 5.09 of the IDA General Conditions and the DFIL.

Procurement Arrangements

The Gambia Public Procurement Institutional Set-up

14. The Gambia Public Procurement is characterized by many layers and key actors that involve the Presidency, the Cabinet, MoFEA, GPPA, the Complaints Review Board (CRB), the National Audit office (NAO), the Procuring organizations (POs), and the private sector bidders.

15. The legislative and regulatory framework provides for oversight functions to be carried out by the GPPA and the CRB.

16. The GPPA, apart from its regulatory role, performs both the control and assurance function for all contracts through ex-ante and post reviews of the procurement proceedings, including an adjudicatory role by virtue of its membership to the CRB.

17. The CRB as provided for in the GPPA Act is to promote and uphold fairness in the public procurement system through judicious and impartial adjudication of matters arising from disputed procurement proceedings. The CRB resolves disputes arising from bidders who claim to have suffered or risk suffering, loss or damage due to the breach of a duty imposed on a PO by the Procurement Law.

18. The CRB is already established as an autonomous body composed of seven members plus secretariat to provide administrative services. Its membership includes, among others; the Permanent Secretary of MoFEA, Director of Procurement Cadre and GPPA.

19. The GPPA 2014 Procurement Act has been revised in order to meet the international standards. The objective is to increase the use of open tendering, reduce the disproportionate use of single source contracting and to facilitate access to information and reduce lack of compliance.

Procurement under the project

20. Procurement for goods, non-consulting and consulting services to be financed by the project will follow the procedures specified in the "World Bank Procurement Regulation of Goods, Works and Non-Consulting Services" under "World Bank Procurement Regulations for Borrowers under Investment Project Financing" dated July 1, 2016 revised in November 2017 and August 2018, and the World Bank's Anti-Corruption Guidelines: "Guidelines on Preventing and Combatting Fraud and Corruption," dated October 15, 2006, revised in January 2011, and as of July 1, 2016.

21. The procuring entity as well as bidders, and service providers, i.e. suppliers, contractors and consultants shall observe the highest standard of ethics during the procurement and execution of contracts financed under the project in accordance with paragraph 3.32 and Annex IV of the Procurement Regulations.

22. The Recipient prepared and submitted to the World Bank for review the PPSD for the project. The PPSD provides the basis and justification for procurement decisions, including the approach to market and selection methods.

23. The Recipient shall prepare and submit to the World Bank the General Procurement Notice (GPN) and the World Bank will arrange for publication of GPN in United Nations Development Business (UNDB) online and on the World Bank's external website. The Recipient may also publish it in at least one national newspaper.

24. The Recipient shall publish the Specific Procurement Notices (SPN) for all goods, works, non-consulting services, and the Requests for Expressions of Interest (REOIs) on their free-access websites, if available, and in at least one newspaper of national circulation in the Recipient's country, and in the official gazette. For open international procurement selection of consultants using an international shortlist, the Recipient shall also publish the SPN in UNDB online and, if possible, in an international newspaper of wide circulation; and the World Bank arranges for the simultaneous publication of the SPN on its external website.

Institutional Arrangements for Procurement

25. The MoH will assume the procurement function and responsibilities for reporting to the World Bank through the PCU. Given the high volume of PCU procurement activities, the PCU will set up a contracts committee which will be chaired by the Permanent Secretary (or designee) and comprises the senior officers of the PCU and a representative of the MoH Procurement Unit. The committee will have the following responsibilities: (a) reviewing, verifying, and ascertaining that all procurement and disposal have been undertaken; (b) approving the selection of the successful bid or proposal; (c) ensuring that the PCU does not pay in excess of prevailing market prices; (d) reviewing and approving aggregation of procurements, where proposed; (e) reviewing and approving the use of lots, where packaging into lots has been proposed; (f) approving the list of consultants qualified to submit proposals; (g) approving the list of suppliers/contractors to be given requests for quotations; and (h) reviewing the quarterly reports on awarded contracts. The full-time PCU procurement specialist and procurement assistant will continue to provide procurement support to the project during implementation and a procurement officer will be recruited to assist with the increasing workload.

26. **Procurement management**: The PCU will assume the overall planning and selection processes as provided for in the Financing Agreement. Based on the outcomes of the PPSD, the PCU has prepared a detailed Procurement Plan covering the first 18-month of the project including the procurement activities with relevant procurement/selection methods.

27. The PCU's Procurement Team will work closely with the Accredited Procurement Specialist of the World Bank office. They will benefit from procurement clinics and training organized by the World Bank in order to be familiar with the new procurement framework.

28. **Filing and record keeping**: The Procurement Procedures Manual will set out the detailed procedures for maintaining and providing readily available access to project procurement records, in compliance with the Loan Agreement. The Procurement Officer is responsible for maintaining the records. The logbook of the contracts with a unique numbering system shall be maintained. In addition, all contracts and related procurement documents including post review contracts will be uploaded into STEP.

29. The signed contracts as in the logbook shall be reflected in the commitment control system of the Recipient's accounting system or books of accounts as commitments whose payments should be updated with reference made to the payment voucher. This will put in place a complete record system whereby the contracts and related payments can be corroborated.

30. The recruitment of civil servants as individual consultants or as part of the team of consulting firms will abide by the provisions of paragraph 3.23 (d) of the Procurement Regulations.

Project Procurement Strategy for Development:

31. As part of the project preparation, the Recipient (with support from the World Bank) prepared its PPSD, which describes how fit-for-purpose procurement activities will support project operations for the achievement of PDOs and deliver Value for Money. The PPSD is linked to the project implementation strategy, ensuring proper sequencing of the activities. It considers institutional arrangements for procurement; roles and responsibilities; thresholds, procurement methods, and prior review, and the requirements for carrying out procurement. They also include a detailed assessment and description of State Government capacity for carrying out procurement and managing contract implementation, within an acceptable governance structure and accountability framework. Other issues taken into account will

include the behaviors, trends and capabilities of the market (i.e. Market Analysis) to inform the Procurement Plan. The PPSD concluded that the operational context allows the transparent and successful execution of the contracts to be undertaken by this project. The harmonization of the new World Bank procurement framework with the local public procurement rules for the implementation of World Bank donor funded projects and programs is still a challenge. An important capacity-building mechanism for the project's procurement actors of the project under effective World Bank supervision would be essential to bridge any capacity gaps between the local rules and World Bank procurement rules.

Procurement Plan:

32. The Recipient has prepared a detailed 18-month Procurement Plan to which the WBG has provided No Objection in STEP. The Procurement Plan will be updated in agreement with the World Bank Team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

Implementation Support Plan

33. **The WBG implementation support team.** The project team provided implementation support to the MCNHRP (P143650) and has experience working with the MoH. The task team leader, who is based in Banjul, Gambia, is with the Health, Nutrition, and Population Global Practice and leads the WBG Global CRVS Program. The task team leader led the policy dialogue with the MoH during project preparation and will continue to do so during implementation. The specialists in FM, procurement, and environment are all based in Dakar, Senegal, and will be available to provide regular support to the MoH. In addition, the social development specialist, based in Washington, DC, is familiar with The Gambia portfolio and will undertake visits twice a year on supervision missions (in-person or virtual). Other WBG experts will provide guidance and will join the implementation support missions (in-person or virtual), as necessary.

34. **Consultants.** The WBG will hire consultants, as necessary, to provide just-in-time technical advice and build the capacity of the MoH staff.

35. **Missions and site visits.** Implementation support missions (in-person or virtual) will be undertaken twice a year but may be more frequent in the first year to ensure that appropriate support is provided in the initial critical implementation period. These missions typically review and provide support on technical activities, procurement, FM, safeguard arrangements, M&E, and institutional arrangements. During the missions, site visits may be made to provide an opportunity to interact with government officials and personnel implementing the project in the regions and communities, as well as with project beneficiaries. The World Bank team will use the guidance provided in the note, " Streamlined Fiduciary Implementation Support Measures for Active World Bank-financed Operations given Travel Limitations due to COVID-19 Pandemic" if they cannot carry-out in-person support missions. An Aide Memoire with agreed-upon actions will be prepared at the end of each mission, and the WBG will prepare an implementation status and results report twice a year, which will be publicly disclosed.

36. **Financing of implementation support plan.** The WBG country office will allocate funds annually for project implementation support, which will cover activities such as the following:

(a) Provide staff time and travel-related mission expenses.

(b) Ensure compliance with legal agreements to meet WBG fiduciary obligations.

(c) Provide fiduciary support and oversight in preparation of terms of reference, bidding documents, contracting, and contract management of individual and firm consultants.

(d) Provide environmental and social safeguard support and oversight.

(e) Monitor and assess progress and results and address implementation challenges.

(f) Provide hands-on training on FM, disbursement, procurement, social safeguards, and environment safeguards.

37. The project will require the following implementation support in the first year. The implementation support plan will be revised after the first year of implementation.

Table 1.3: Required Project Implementation Support

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Senior health specialist/CRVS expert (task team leader)	14	4	The task team leader will oversee the entire operation to ensure project performance toward the PDO, provide technical inputs, oversee M&E of the operation, and manage partner relationships.
Senior economist	5	1	The senior economist will oversee the impact evaluation baseline data collection and analysis.
IT officer	4	1	The senior IT officer will provide inputs into the electronic CRVS implementation.
SBCC specialist	4	1	The SBCC specialist will provide overall support for the implementation of the SBCC.
Health specialists	8	0	The health specialists will provide technical advice.
Procurement specialist	6	0	The procurement specialist will support the implementing agencies on related issues.
FM specialist	6	0	The FM specialist will support the implementing agencies on related issues.
Social development specialist	3	0	The social development specialist will ensure ESMF is properly implemented.
Environmental safeguards specialist	3	2	The environmental safeguards specialist will ensure ESMF compliance.

38. Based on the outcome of the FM risk assessment, the following implementation support plan is proposed. The objective of the implementation support plan is to ensure the project maintains a satisfactory FM system throughout the project's life.

Table 1.4: FM Implementation Support Plan

FM Activity	Frequency
Desk reviews	
IFRs review	Quarterly
Audit reports review	Yearly
Review of other relevant information such as interim internal control systems reports	Continuous as they become available

On site visits	
Review of overall operation of the FM system	Each semester Implementation Support Mission, and Annual when the risk become Moderate
Monitoring of actions taken on issues highlighted in audit reports, auditors' management letters, internal audit and other reports	As needed
Transaction reviews (if needed)	As needed
Capacity building support	
FM training sessions	As and when needed

ANNEX 2: Cost-benefit Analysis

1. An economic analysis is carried out to inform the decision to undertake this project. The analysis is built around the part of the PDO, focusing directly on improved utilization of essential health care services. Given the multitude of interventions supported by the project, it is impossible to measure the impact of each single intervention without overestimating the benefits, hence this analysis centers on project Component 1. A CBA is conducted to determine whether the dollar benefits of that component are likely to outweigh its dollar costs. The NPV, IRR, and BCR are the metrics used to assess the expected return on investment of Component 1.

Methodology

2. **Project costs.** The estimated costs included in the CBA reflect the marginal costs of the project compared to the status quo. Costs include all the resources added to the system. In this case, the estimated amount of the IDA grant expected to be devoted to activities under Component 1 (US$27 million, representing 90 percent of the IDA financing and 77 percent of the total project costs respectively), is considered. The estimated cost for Component 1 (in US$, million) per year is shown in the Table 2.1.

Table 2.1. Estimated Cost of Component 1 (in US$, millions per year)

	2022	2023	2024	2025	2026
Estimated cost (US$, millions)	5.44	8.60	7.18	4.64	1.14

Estimating Expected Project Benefits

3. Drawing on data from the project Results Framework, it is estimated that the number of maternal deaths expected to be averted (that is reduction in MMR) and the number of deaths averted among infants (that is reduction in infant mortality ratio) resulting from increased utilization of health and nutrition services.

4. In terms of maternal deaths averted through the health interventions, the intermediate results indicator 'number of deliveries attended by skilled personnel' is used as a proxy for the increase in maternal health service utilization. The baseline of deliveries attended by skilled personnel before project implementation is 58,575. The project anticipates providing 879,000 cases of skilled birth attendance over the project period. However, the number of deliveries attended by skilled personnel is adjusted to account for such deliveries that would occur without the project. Hence the number of expected skilled deliveries because of the project is estimated by deducting the baseline quantity from the anticipated quantity for every year, which means the project would produce 644,700 cases of births attended by skilled personnel. Findings by Bell, Bullough, and Graham (2001)[17] estimate that around 16 to 33 percent of all maternal deaths may be avoided through prevention of complications such as obstructed labor, eclampsia, puerperal sepsis, and obstetric hemorrhage by skilled attendance at delivery. Notwithstanding this expert

[17] 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.

finding, a conservative 10 percent is applied to estimate the reduction in maternal mortality because of the increased number of skilled deliveries. This is because available data show an average MMR decrease of less than three percent in The Gambia over the recent years. Thus, project could potentially contribute to 64,470 maternal deaths being averted (Table 2.2).

5. The number of children immunized is the intermediate indicator used as a proxy to estimate the increased utilization of child health and nutrition services. The project expects to immunize 1,027,000 children. As of baseline, 72,412 children are immunized. Hence it was assumed that 72,412 children would be immunized each year without the project, which means that the project intervention would account for 737,352 cases of children immunization. According to the WHO, along with immunization, more than 60 percent of all under-five child deaths can be avoided with proven, preventive care and treatment such as continuous breast-feeding and adequate nutrition.[18] This project devotes funds to interventions to deworm children ages 12-59 months, as well as to treating children under five years with appropriate antimalarial drugs and for moderate or severe acute malnutrition respectively, which the proxy indicator does not capture. Yet it is assumed conservatively that the project would result in 10 percent decrease in infant mortality. Thus, as shown in Table 2.2, an estimated 73,735 infant deaths could be avoided because of the project.

Table 2.2. Estimated Number of Maternal and Child Lives Expected to Saved by the Project by Year

	2023	2024	2025	2026	Total
Maternal deaths averted	6,134	12,543	19,343	26,443	**64,470**
Infant deaths averted	7,259	14,659	22,159	29,659	**73,735**

Converting Project Benefits to Monetary Terms

6. To calculate the benefits of reducing maternal and child mortality, each productive year of a mother's or a child's life is valued as the per capita gross national income, remaining constant throughout the benefit accrual period. The productive lifespan is defined as lasting from 15 until 60 years of age.

Key Underlying Assumptions

- Life expectancy at birth in The Gambia = 61 years
- Working age= 15-60 years
- Benefit accrual period = five years
- A 16 percent discount rate, the current interest rate from The Gambia Central Bank, was used to discount costs and benefits over benefit accrual period, as it reflected the current opportunity cost of capital investment in The Gambia
- Average of gross national income per capita = US$652.50 for the benefit accrual period

[18] World Health Organization. 2011. "Child Mortality, Millennium Development Goal (MDG) 4" accessed from *https://www.who.int/pmnch/media/press_materials/fs/fs_mdg4_childmortality/en/*

- Inflation and economic growth remain constant
- Birth and death rates are held constant

CBA analysis results

7. Under the base case scenario, Component 1 would yield a BCR of 2.68 (Table 2.3), indicating that for every dollar invested, the project would produce an economic return of US$2.68. The investment of US$27 million would generate economic benefits with a positive NPV of US$36.51 million. The IRR is 126 percent, which is substantially higher than the available 16 percent cost of capital in The Gambia.

Table 2.3. Results of CBA Base Case Scenario and Sensitivity Analyses

	Discount Rate (%)	NPV (US$, millions)	IRR (%)	BCR
Base case scenario	16	36.51	126	2.68
Scenario 1	10	44.51	126	2.90
Scenario 2	20	32.11	126	2.54

Limitations

8. Beneficiaries, besides women and children, were omitted. Effects of quality enhancements were not considered. Implementation of The Gambia's social insurance, which is expected to assist poor Gambians with out-of-pocket costs, was not factored in this analysis. Without considering such aspects, the impact of the project is likely to be underestimated. The discount rates are high since it is fragile environment.