



1. Project Data

Project ID

P143650

Project Name

GM-Maternal & Child Nutr & Hlth Results

Country

Gambia, The

Practice Area(Lead)

Health, Nutrition & Population

L/C/TF Number(s)

IDA-56230,IDA-59420,IDA-D0500,IDA-D1600,IDA-H9230,TF-16640

Closing Date (Original)

31-Jul-2019

Total Project Cost (USD)

21,270,266.95

Bank Approval Date

21-Mar-2014

Closing Date (Actual)

30-Jun-2020

IBRD/IDA (USD)
Grants (USD)

Original Commitment

3,680,000.00

5,000,000.00

Revised Commitment

21,178,573.72

5,000,000.00

Actual

21,270,266.95

5,000,000.00

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2. Project Objectives and Components

a. Objectives

As stated in Schedule 1 of the April 9, 2014 Financing Agreement, "The development objective of the project is to increase the utilization of community nutrition and primary maternal and child health services in selected regions in the Recipient's territory." The Project Appraisal Document (PAD, pages viii, 8, and 27) stated the same objective. The statement of project objectives remained unchanged, but several outcome targets were increased to reflect two Additional Financings (AFs) and the expansion of coverage to two additional



regions. Given that both the original and increased targets for these outcome indicators were exceeded, this review does not apply a split rating.

b. Were the project objectives/key associated outcome targets revised during implementation?
Yes

Did the Board approve the revised objectives/key associated outcome targets?
Yes

Date of Board Approval
22-Mar-2019

c. Will a split evaluation be undertaken?
No

d. Components
Original Components:

The project was designed to support the following components in three regions identified in the PAD as having the highest levels of infant and child mortality and stunting: North Bank River-West, Central River Region, and Upper River Region.

Component 1: Community mobilization for social and behavior change (original estimate US\$2.50 million; revised estimates under AF#1 and AF#2: \$4.15 million and \$5.15 million, respectively; actual cost: \$4.31 million, or 172 percent of original estimate): This component focused on community-based promotion of family and community practices favoring child survival, growth and development, and care seeking behaviors for improved maternal and child health and nutrition outcomes through:

(i) conditional cash transfers (CCTs) to communities and village support groups to increase demand for and utilization of health and nutrition services through counseling and timely referrals for life-saving health services (e.g., hygiene, sanitation, counseling on infant and young child feeding, delayed first pregnancy and child spacing, and referral of pregnant women and children with danger signs to health centers). Village development committees were to sign results-based financing (RBF) contracts with regional health team and receive payments for achievement of performance indicators, verified by the National Nutrition Agency and counter-verified by community-based organizations. Payments could be used for operating costs, community mobilization, and performance-based incentives to individual group members;

(ii) CCTs to individual women to increase utilization of antenatal care, specifically a first antenatal care visit during the first trimester and at least three more visits during the pregnancy. Payments would be made by health centers providing the services, verified by the National Nutrition Agency; and

(iii) social and behavior change communication (SBCC), including advisory services and training, to promote behavior changes and increased demand to improve health and nutrition-related household practices.



Component 2: Delivery of selected primary health care services (original estimate: US\$3.78 million; revised estimates under AF#1 and AF#2: \$5.83 million and \$11.53 million, respectively; actual cost: \$12.37 million or 327 percent of original estimate): This component aimed to support the delivery of nutrition and health care services at primary and referral health levels through:

(i) performance-based grants to health centers for the delivery of a package of maternal and child health and nutrition services at primary and referral levels. Health centers would sign an RBF contract with the Ministry of Health and Social Welfare RBF Committee and receive quarterly payments for achieved performance based on service quantity and quality, following quantity verification by the National Nutrition Agency and quality verification by regional health teams and community-based organizations (capturing patient feedback). RBF payments could be used for material and equipment, training, consulting services, operating costs, and staff bonuses; and

(ii) start-up support for effective service delivery, including the implementation of selected health care waste management measures.

Component 3: Capacity building for service delivery and results-based financing (original estimate: US\$2.4 million; revised estimates under AF#1 and AF#2: \$3.20 million and \$4.00 million, respectively; actual cost: \$4.00 million or 167 percent of original estimate): This component aimed to support:

(i) capacity building of key implementers (village-level, service providers, regional and national levels) for effective implementation of RBF, including: governance and management; Health Management Information System (HMIS, including district-level); community organization and mobilization; behavior change communication; institutionalization of RBF; regions' use of tools and innovations to improve verification and supervision of quality; and mentoring and peer learning among RBF stakeholders;

(ii) monitoring and evaluation (M&E), independent verification, operations research, and learning and knowledge management;

(iii) project implementation, management, and oversight; and

(iv) oversight and support of RBF through performance agreements.

Revisions to Components:

The components were revised three times during implementation.

- ***The December 18, 2014 restructuring*** added **Component 4: Emergency Ebola Response (original estimate: \$0.5 million; actual: 0.5 million)**: Financed through reallocation of project funds, this new component supported the government's Ebola Emergency Preparedness and Response Plan, with the World Health Organization implementing. It was to support training, establishment of a public health emergency operations center, and community-level activities.
- ***The April 24, 2015 first additional financing*** revised components to: (i) support food and nutrition security activities and their incorporation in behavior change strategy, community RBF contracts, and a baby-friendly community initiative; (ii) expand coverage to two additional regions (Lower River



and North Bank River-East); and (iii) rename Component 2 (Delivery of Community Nutrition and Primary Health Care Services) to reflect the new community nutrition activities.

- **The January 9, 2017 second additional financing:** (i) introduced unconditional cash transfers and expanded food and nutrition security activities initiated under the first AF to address economic hardships on households and the food and nutrition security crisis which risked undermining PDO achievement; (ii) expanded support for quality of health services; and (iii) added **Component 5: Contingent Emergency Response (original estimate: 0; revised estimates: 0; actual: 0)** to address any emergencies related to food insecurity and short-term economic poverty. It was never triggered.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

The total original cost estimated in the PAD was US\$8.68 million, of which \$3.68 million was to be financed by an IDA grant and \$5.0 million by a grant from the Multi-Donor Health Results Innovation Trust Fund. The total estimated cost was revised upwards to \$13.68 million in April 2015, when AF of \$5.0 million (comprised of an IDA credit of \$2.48 million and an IDA grant of 2.53 million) was approved. Total estimated costs were revised again – to \$21.18 million in January 2017 – when \$7.50 million more in IDA financing (an IDA credit of 3.2 million and an IDA grant of \$4.3 million) was approved. These funds were fully utilized, as reflected in the ICR's final cost data (Annex 3). The actual costs of Components 1 (community mobilization) and 3 (capacity building) were 170 percent of original estimates, while the actual cost of Component 2 (health and nutrition service delivery) was more than triple the original estimate.

No Government counterpart financing was envisaged in original or revised estimates, and none was reported in the ICR's final costs. Nevertheless, the PAD (para. 58 under the Sustainability section) did state that "the government is starting to show commitment by allocating \$0.2 million for project management."

The project underwent five restructurings and/or additional financings, itemized here by date and highlights:

- **December 18, 2014 Restructuring** included revisions to the results framework and components, and reallocation of funds across disbursement categories.
- **April 24, 2015 1st Additional Financing** included a \$5.0 million increment in financing, revisions to the results framework and components, and changes in the implementation schedule.
- **January 9, 2017 2nd Additional Financing** included a \$7.5 million increment in IDA financing, revisions to the results framework, reallocation of funds across disbursement categories, changes to implementation arrangements and schedule, and an extension of the closing date from July 31, 2019 to July 31, 2021.
- **December 7, 2017 Restructuring** involved a reallocation of funds across disbursement categories.
- **March 22, 2019 Restructuring** included revisions to the results framework, components, and implementation schedule; a reallocation of funds across disbursement categories; and a second change to the closing date, advancing it from the previously extended date of July 31, 2021 to June 30, 2020.



Changes to the results framework are discussed in Sections 4 (Efficacy) and 9 (M&E Design, Implementation, and Utilization). The actual closing date was June 30, 2020, eleven months after the original closing date of July 31, 2019.

3. Relevance of Objectives

Rationale

The PDO is highly relevant to current country conditions. The ICR (p. 14) noted that maternal and child health and nutrition indicators have improved but remain a challenge, especially for those living in rural areas and those in the poorest wealth quintiles. The Bank's Systematic Country Diagnostic (SCD), published in May 2020, notes that over the past decade malnutrition has been the main risk factor contributing to lost years due to death and disability. Twenty-five percent of children are stunted and 12 percent are wasted, with the heaviest burden in rural areas, due to inadequate access to: adequate food and care; clean water, sanitation, and hygiene; and primary health services. Maternal and childhood vulnerability and morbidity are exacerbated by a lack of basic maternal and child health services. The Gambia continues to suffer from a weak health system, characterized by: its inability to overcome demands and pressures of rapid population growth; lack of financial resources; health expenditures that continue to favor tertiary and secondary care over primary care; and inadequate access to care in rural areas.

The PDO is also highly relevant to the current development priorities of the country. Among the eight strategic priorities of the Government's National Development Plan for FY2018-2021 is strategic priority #4. "Investing in our people through improved education and health services, and building a caring society." The expected results articulated under this strategic priority include: strengthened health services for mothers and children and their improved use; improved food security; improved access to water, sanitation, and hygiene; exclusive breastfeeding; reduced mortality rates of mothers, neonates, infants, and children; and improved nutrition status, particularly of mothers and children, as measured by reductions in stunting, underweight, and maternal anemia.

Moreover, the PDO is highly relevant to the Bank's current assistance strategy for The Gambia. World Bank's Country Engagement Strategy (CEN) FY18-21, published on May 16, 2018, offers a bridge program of assistance, following the second IDA-AfDB Joint Partnership Strategy, which expired in FY16. It aims to help the government address immediate-term needs following the political transition of government in 2017. Broadly aligned with the objectives of the new government's National Development Plan for FY18-FY21, the CEN reflects IDA18 priorities for fragile states and the WBG's comparative advantages. Interventions are clustered around two objectives: (i) to restore macroeconomic stability and stimulate inclusive growth, which will support good economic governance and macroeconomic stability essential for recovery, and provide support to the private sector in key areas such as energy, tourism, the financial sector, and agriculture; and (ii) to invest in human capital and build assets and resilience for the poor, through investments in health, education, and social protection. Looking ahead, this second objective maintains its importance in the 2020 SCD, which asserted that "providing better quality education, health



care, and social safety net services will strengthen human development and enhance private sector growth through higher productivity.”

Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

To increase the utilization of community nutrition services in selected regions in the Recipient's territory

Rationale

Rationale (for both objectives)

The project invested in supply- and demand-side activities to improve the availability and quality of essential health and nutrition services for mothers and children in selected, disadvantaged regions, and to stimulate their increased utilization and other healthy behaviors in order to achieve the long-term impacts of improved health and nutrition outcomes among women and children and reduced maternal and child morbidity and mortality. To stimulate increased demand for and utilization of these services and behaviors favoring improved maternal and child health and nutrition, the project provided conditional cash transfers to communities, village support groups, and women and undertook community-based social and behavior change communications. Supply-side interventions focused on improvements to the quality and availability of primary health and nutrition services and essential medicines, and the strengthening healthcare waste management in health facilities. These interventions were carried out under an RBF mechanism, under which performance payments were made to contracted health centers to incentivize improved quality and organization of selected maternal and child health services through the (a) provision of performance-based grants to health centers for the delivery of a package of maternal and child health and nutrition services at primary and referral health facilities; and (b) start-up support for service delivery, including health care waste management procedures. Under the mechanism of RBF contracts with health facilities, quarterly payments to health facilities were made in line with their performance against quantitative and qualitative targets and indicators, established under their contracts. Capacity building activities underpinned the success of these interventions, especially: training and technical support in RBF contract management, supervision and performance monitoring and verification at all levels of the system, and improved quality and use of HMIS data to this end, as well as technical training of service providers to ensure effective delivery of quality services.

The five restructurings (including two AFs) undertaken during project implementation broadened the scope of the project and added complementary activities. All changes were supportive of the original PDO and appropriate for responding to unfolding challenges, lessons, and opportunities during implementation. First, the addition of an Emergency Ebola Response component supported improved preparedness of the country to address/mitigate the emerging issue in West Africa. Second, to address and mitigate growing poverty



caused by poor economic performance and deteriorating food and nutrition security, project coverage was extended beyond the original three target regions to include two additional regions; and a number of community-based interventions focused on improved food security and nutrition were incorporated. Third, a new Contingent Emergency Response component aimed to provide rapid, flexible support in the event of an emergency.

Outputs and intermediate results

- RBF contracts with 345 communities in the project regions focused on health and nutrition promotion and behavior change, and included 10 performance indicators that were monitored through Lot Quality Assurance Sampling surveys or through verification. Resources generated through good performance under these contracts, together with those generated through RBF contracts with health facilities, supported activities to promote child feeding practices; support women's efforts to ensure food availability and child care in their households; boost food security and nutrition through gardens, livestock projects, and child food banks; provide micronutrients to women and children; and establish places for hand washing.
- From a baseline of 0, a total of 37,551 pregnant women were referred to health services, by village health workers and community birth companions, for delivery and pregnancy complication management, surpassing the original target of 10,000 and the revised target of 28,000. This upsurge was precipitated in part by a policy change redefining the role of community birth companions to focus on referring women and accompanying them to health facilities, and also by the use of resources from community RBF contracts to finance their transportation.
- From a baseline of 0, a total of 28,919 hand-washing stations were established according to minimum criteria in the project regions, surpassing the original target of 4,000 and the revised target of 10,000.
- From a baseline of 0, a total of 95 communities were supported in the establishment of child food banks. This fell short of the original target of 250 (set in April 2015, when this new activity was introduced), and surpassed the revised target of 90.
- From a baseline of 633, a total of 888 communities were implementing baby-friendly community activities, falling short of both the original target of 1,100 (set in April 2015, when this new activity was introduced) and the revised target of 950.
- From a baseline of 0, a total of 2,400 vulnerable households received inputs to enhance their food and nutrition security (small ruminants, poultry, and backyard garden/labor saving devices). This fell short of the original target of 3,000 (set in April 2015, when this new activity was introduced), but exceeded the revised target of 1,500.
- One hundred percent of recipients selected for conditional cash transfers met the targeting criteria, surpassing the target of 80 percent (set in January 2017, when this new activity was introduced).
- A total of 2,400 people received unconditional cash transfers, falling short of the original target of 5,000 (set in January 2017, when this new activity was introduced), but exceeding the revised target of 2,300.
- From a baseline of 314, a total of 2,843 community registers were correctly updated on a quarterly basis, exceeding both the original target of 500 and the revised target of 2,110.



Outcomes

- From a national baseline of 47 percent, the share of children 0-6 months who are exclusively breastfed in the five project regions rose to 69.3 percent (calculated on the basis of regional data from DHS 2019/2020), surpassing the target of 60 percent.
- A healthier, more diversified diet for children aged 6-23 months was a key goal of community-based communications and behavior change efforts. Its measurement proved to be challenging with several changes in the standard indicator metrics. The original target of 30 percent of children in this age group consuming at least four out of six food groups (set in April 2015, against a baseline of 19 percent) was increased to 35 percent (in January 2017). The definition was changed to "...at least four of seven food groups," prompting a recalculation and reduction in the project's baseline and target values to 7.6 percent and 20 percent, respectively. End-of-project data reveal a national average of 22.2 percent (DHS 2019/2020, no regional breakdowns available), but with the caveat of yet another change in definition/metrics ("at least five of eight food groups"). Nevertheless, the endline impact evaluation found improvements in minimum meal frequency and acceptable diet in the project communities.
- From a baseline of 0, a total of 735,155 children between the age of 6 and 59 months received Vitamin A supplementation under the project, surpassing the original target of 385,000 and the revised target (set in April 2015) of 475,000. (Source: HMIS)
- A total of 179,850 post-partum mothers received vitamin A supplementation, surpassing both the original target of 23,000 and the revised target of 145,000.
- From a baseline of 9,000, a total of 386,393 pregnant women received iron and folic acid supplements, far surpassing the original target of 15,000 and revised target of 18,000.
- From a baseline of 0, a total of 14,037 children under the age of five in the project area were treated for moderate or severe acute malnutrition, surpassing the original target of 4,000 and the revised target of 5,000.
- From a baseline of 90,000, a total of 1,865,788 clients (pregnant/lactating women, adolescent girls, children under five) were reached by basic nutrition services provided under the project, far surpassing the original target of 484,000 and the revised target of 593,000.

Rating
High

OBJECTIVE 2

Objective

To increase the utilization of primary maternal and child health services in selected regions in the Recipient's territory

Rationale

Outputs and intermediate results

- A number of the outputs and intermediate results listed under Objective 1 also contributed to this objective, most notably: cash transfers, community referrals to health facilities, community-based



- promotion of healthy behaviors (including the uptake of modern contraception), and the establishment and maintenance of community registers.
- A total of 2,440 health personnel from the project regions received training under the project to improve their skills and the quality of care, far surpassing the original target of 400 and the revised target of 1,715. RBF resources also financed other tools and initiatives to improve quality of care and the construction of incinerators for proper management of clinical waste.
 - The Quality of Care score in the five regions (averaging 73 percent) was much higher than that in the two urban non-project regions (averaging 46 percent).
 - On November 16, 2018, the Ministry of Health and Social Welfare adopted a revised health financing policy that incorporates RBF.
 - From a baseline of 38, a total number of 996 health workers (including central and regional-level health managers) were trained in RBF management, surpassing by far both the original target of 188 and the revised target of 610.
 - One hundred percent of project health facilities reported that they receive client tracer and satisfaction survey feedback at least three times during the calendar year, surpassing the target of 70 percent.
 - Eighty-three percent of project health facilities scored at least 75 percent on the quality of services checklist, falling short of the original target of 100 percent and essentially meeting the revised target of 85 percent.
 - A total of 305 health personnel were trained on Ebola prevention and management, achieving triple the target of 100. A public health emergency center, along with a call center, were established, equipped and staffed.
 - The Contingent Emergency Response component was never triggered.

Outcomes

- From a baseline of 12,925, a total of 70,329 pregnant women in the project area undertook an antenatal care visit during the first trimester of pregnancy, far surpassing the original target of 5,900 and the revised targets of 5,900 and 26,000 (set, respectively in April 2015 and January 2017). This outcome is plausibly linked to conditional cash transfers provided under the project to women who booked an antenatal care visit during the first trimester, and to additional cash transfers provided to women if they attended antenatal care in accordance with the four visits recommended in the (pre-2018) Focused Antenatal Care Protocol. (Since 2018, this protocol has been amended to recommend at least eight visits.)
- From a baseline of 43 percent (based on DHS 2014 regional data compiled for the five project regions), 79 percent of deliveries in the five regions were made in health facilities (based on DHS 2019/2020 regional data compiled for project regions), surpassing the target of 60 percent.
- From a baseline of 8,885, a total of 139,987 births were attended by skilled health personnel, far surpassing the original and revised (January 2017) targets of 15,000 and 87,115.
- From a baseline of 3.5 percent for the five project regions, 15 percent of women of reproductive age were using modern methods of family planning by the project's end (DHS 2013 and DHS 2019/2020, regional data), fully achieving the target of 15 percent. By the project's end, a total of 188,034 women were new acceptors of modern contraception, a significant increase over the baseline of 12,925 users, and more than double the target of 90,000 (set in March 2019).



- From a baseline of 6,641, a total of 480,024 children between 12 and 19 months were dewormed, far surpassing the original target of 40,000 and the revised target of 143,500. (Source: HMIS, community registers)
- A total of 1,894,288 people have received essential health, nutrition, and population services under the project, far surpassing the target of 375,834. Of these, 50 percent are women, fully achieving the original target of 50 percent. (Source: HMIS, community registers). A follow-up discussion with the task team (2-12-21) noted that The Gambia (along with many other countries) is challenged to report on the gender breakdown of those receiving services because frontline facilities do not keep this data. Since OPCS insists on reporting on this corporate results indicator, it was decided to keep to conservative estimates for baselines and targets of 50 percent. The achievement of the 50 percent target reported in the ICR is also a very conservative estimate. But, in the absence of disaggregated data from the facilities, the team was hesitant to report a larger share of female beneficiaries, even though they are almost certain that the target was exceeded, given the nature of the services.
- Client tracer and satisfaction surveys revealed a high satisfaction rate across all health regions (98 percent or more), with minor issues noted, including: long wait times to see a provider; some prescriptions not being available in the facility, leading to the client paying for these at other pharmacies; and poor attitude of certain health care workers.
- A follow-up discussion with the task team (2-12-2021) revealed that investments under the Ebola component improved the country's capacity and readiness for managing the response to COVID-19. The public health emergency operations center and call center are being used for COVID information and management. The training of health personnel and other first responders and workers at points of entry in infection prevention and control, case management, and rapid response is highly relevant and actively being applied to the needs and demands of the current COVID crisis. Also relevant and actively applied to The Gambia's COVID response are the communication material and supplies provided to all hospitals and health centers promoting and enabling handwashing, simulation exercises to test coordination and operations under the project, and acquired experience and capacity in social mobilization and communication and community engagement for prevention and control.

Rating
High

OVERALL EFFICACY

Rationale

Project outcomes surpassed almost all targets (both original and formally revised) for indicators measuring access to – and use of – maternal and child health and nutrition services in the project communities. The only target not surpassed was fully met.

Attribution of outcomes to the project is strong, based on the project's implementation of a well-defined and plausible causal chain, and the introduction of amendments to the project's interventions, designed to address challenges and opportunities emerging during implementation. The ICR noted (p. 32) that most donors active in The Gambia during project design and implementation (EU, WHO, World Food Programme and UNICEF) were largely focused on policy discussions. It does note that the EU supported a project



through UNICEF, implemented by the National Nutrition Agency, that paid women cash transfers whether or not they delivered in a health facility, whereas the project cash transfers encouraged facility births. The EU-financed project's external evaluation did, nevertheless, find an increase in health facility deliveries. In a follow-up discussion (2-12-21), the task team provided more evidence of strong attribution. The EU's support did overlap with the initial three regions supported by the Bank-financed project, but its scale was very small compared with the Bank's. The EU's intervention benefited 5,500 mothers served by 10 health facilities, while the Bank's support benefited two million mothers and children served by 37 health facilities.

Counterfactual. While not explored in the ICR's efficacy section, a follow-up discussion with the task team (2-12-21) provided insights about **the counterfactual of no project**. In the absence of the project, the Ministry of Health would have continued its "business as usual" of input-based financing, under which government financing does not go to health facilities. Rather, government financing was allocated to salaries and the procurement of drugs and their distribution to facilities. RBF, as designed under the project, enabled health facilities to receive funding based on performance, providing them with liquidity and flexibility to finance needed repairs, operations, maintenance, activities, and individual performance awards. Since 2018, the government has started allocating funds to RBF. The project's success has also generated cofinancing for RBF under follow-on operations. In 2019, the new Minister of Health received considerable positive feedback from his initial visits to health facilities about the effect RBF has had on service delivery and quality. In the absence of RBF (performance incentives, systematic monitoring of quality, and liquidity at the service level), facilities' ability to deliver quality services would have been reduced. In the absence of this project, quality of health care would not have been as strong as it is today. Quality of care levels in the five project regions are considerably higher (at 72 percent) than for the non-project regions (at 46 percent). Indeed, the salient features and benefits of RBF (with its disciplined emphasis on service quality, and its success in providing liquidity at the service provider level to ensure quality) triggered strong community support and rendered the provision of health and nutrition services resilient to a difficult context during implementation (including transitions in government, poor economic performance, and erratic rainfall).

In the absence of the project's Ebola Preparedness Component, the Gambia would have been less equipped to rise to the challenge of the COVID-19 crisis. Even though the COVID-19 crisis was not anticipated at the time this component was added, and even though the threat of an Ebola outbreak did not materialize, the investments and activities supported under this component have boosted capacity and readiness for managing the response to COVID-19.

Overall Efficacy Rating

High

5. Efficiency

An end-of-project cost benefit analysis (CBA) showed that the project generated a positive net present value (NPV) of \$7.38 million. At 179 percent, the internal rate of return was substantially higher than the 16 percent cost of capital in the country. For every dollar invested, the project yielded an economic return of \$1.74. In short, the CBA results reveal that the project was a sound economic investment that yielded high benefits. It is



important to note that the CBA conducted at appraisal, which estimated the NPV at \$1.5 million and benefit/cost ratio at 2.0, was based on 29 percent of project costs and only looked at a fraction of component 1. The CBA for the ICR considered nearly the total project cost (97 percent).

The project was strategic both in its focus on the most vulnerable groups and in its design, which focused on three mutually reinforcing supply- and demand-side activities favoring greatest impact and efficiency. Investments in preserving and protecting the health and nutrition of mothers and children are highly cost effective, as they prevent morbidity and mortality of these populations and enhance the wellbeing and resilience of families and households, as well as children's success in school, and their wellbeing, capacities, and productivity as adults. The design included: incentives (cash transfers) and communications to encourage healthier behaviors and practices, incentives (performance payments) to health centers to enhance the quality and delivery of priority services, and the strengthening of capacity of a range of actors from central to community levels to manage and oversee service provision and utilization.

An analysis of planned versus actual costs by component reveals an ongoing effort to reinforce and expand project activities, judiciously, to address evolving challenges and opportunities. Two AFs approved during project implementation supported: the expansion of coverage to an additional two regions; and the inclusion of supplemental food and nutrition security interventions to mitigate the negative effects of an economic downturn that increased vulnerabilities of target groups. They also supported the strengthening of Ebola preparedness, as Ebola emerged as a public health concern during implementation. All of these were effective and efficient responses to issues that threatened PDO achievement. Actual costs of Components 1 (community mobilization), 2 (service delivery), and 3 (capacity building for RBF) were, respectively, 172 percent, 327 percent, and 167 percent of original estimates. With the support under these enhanced components and the new Ebola preparedness components, funds were fully utilized and almost all outcome targets were surpassed.

Implementation was very efficient. The project took 17 months from concept to first disbursement, lower than averages for The Gambia (20.3 months), the Africa Region (24 months), and all of the World Bank's regions (24 months). The total amount of \$21.2 million was disbursed ahead of schedule, an indication of fast implementation, with the project closing in June 2020, 13 months prior to the closing date set after AF#2. At \$3.13 million, or nearly 15 percent of project costs, the ICR deemed administrative costs to be reasonable, in light of the use of RBF mechanisms both for supply- and demand-side activities, the project's expanded scope and coverage, and the two additional financings. Moreover, the RBF arrangements appear to have been instrumental in the project's success in exceeding most targets. Most of the Project Implementation Committee members remained throughout implementation, their institutional memory helping to facilitate implementation.

Nevertheless, there were a few shortcomings. An administrative error led to the wrong pricing being applied during the first 18 months of implementation, culminating in facilities receiving some 13 percent less than anticipated from incentivized indicators. The ICR pointed out that it is not unusual to periodically review and adjust prices in RBF projects during implementation. The lack of a quarantine clause for food and nutrition security inputs led to the death of approximately 400 livestock. Lessons from this first procurement were learned



and applied for the second batch procurements, and no deaths were observed. Health care waste management activities suffered delays, but these were adequately addressed in the last 18 months of the project.

Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 <input type="checkbox"/> Not Applicable
ICR Estimate		0	0 <input type="checkbox"/> Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

The relevance of the PDO is rated high, as it was highly responsive to: current country conditions (poor, albeit improving, health and nutrition indicators for mothers and children, especially in rural areas, and poor, albeit improving, access to health and nutrition services); the World Bank's Country Engagement Strategy FY2018-2021, which stresses the importance of investing in human capital, including maternal and child health; and the current development priorities of the country, which prioritize the need to improve maternal and child health and nutrition status through strategic investments in basic health services and community-based nutrition. Efficacy is rated high as nearly all targets set (and revised upwards during implementation) for improved access and utilization of nutrition and health services and healthier behaviors were surpassed. Efficiency is rated substantial. The cost-benefit analysis confirms that the project was a sound economic investment that yielded high returns. The project was strategic and efficient: (i) in its focus on the most vulnerable populations (women and children) living in regions with the poorest health indicators; and (ii) in its design, which focused on mutually reinforcing, high impact, supply- and demand-side interventions, and implementation arrangements relying on results-based financing, under which a range of implementers were contracted and rewarded for good performance against performance indicators embedded in the contract. These ratings are indicative of essentially no shortcomings in the project's preparation and implementation, producing an Outcome rating of Highly Satisfactory.

a. **Outcome Rating**
Highly Satisfactory

7. Risk to Development Outcome



The ICR presented a number of factors indicating that the development outcomes achieved by the project are likely to be sustained. These factors are reflective of the government's strong commitment to the sustainability and further improvement of outcomes through its policy decisions, budget allocations, and institution building to consolidate gains. **First**, an RBF Sustainability Road Map, developed in September 2018 and currently under implementation, proposes a national RBF institutional framework, with details on institutional sustainability, financial sustainability, and operational sustainability. Successfully transitioned from the National Nutrition Agency to the Ministry of Health, RBF program implementation has received budget allocations of \$0.25 million in 2019 and \$0.8 million in 2020; and prior to the follow-on project's effectiveness, the government's budgetary allocation financed performance-based grants to health facilities. **Second**, The Gambia's National Development Plan (2018-21) calls for the establishment of social health insurance in support of its drive to achieve universal health coverage. To this end, a Bill to establish a National Health Insurance Scheme was approved by the Cabinet in September 2020 and submitted to the National Assembly. This should mitigate the risk of limited service access among those who cannot afford to pay and contribute to the sustainable financing of service delivery. **Third**, the Bank's follow-on Essential Health Services Strengthening Project, approved on October 9, 2020, is designed to build on the gains of the project, including the financing of performance-based financing grants to health facilities for delivery of an essential health care package, and the expansion of the maternal and child health and nutrition services to include: integrated management of neonatal and childhood illnesses, infectious diseases, non-communicable diseases, and emergency obstetric care. The project will also strengthen SBCC activities and capacity.

The COVID-19 pandemic is having detrimental impacts on development outcomes, both project-specific and sector-wide, particularly: a reduction in the fiscal capacity of government; constrained availability of drugs and other medical inputs; and increased social fragility due to lack of income and the spread of misinformation. The project's strengthening of Ebola emergency preparedness has been instrumental in the country's response to COVID-19, but essential health services delivery during the first half of 2020 was adversely affected by shutdown measures early in the response and fear of contracting the virus. The Gambia COVID-19 Preparedness and Response project, approved on April 2, 2020, is supporting implementation of the government's National COVID-19 Preparedness and Response Plan and continuity of essential services.

8. Assessment of Bank Performance

a. Quality-at-Entry

The PDO was well aligned with the government's health sector priorities and policies (see Section 3 on Relevance of Objectives) and was appropriately targeted to vulnerable populations (mothers and children) living in the regions with the poorest health services and outcome indicators. The design was grounded in extensive analytical work and selected exchange visits. A pre-project pilot facilitated learning and insights about supply- and demand-side elements of the RBF approach. Several preparatory studies informed the structure and pricing of services and the management of gender dimensions. South-South Learning Exchange visits to RBF programs implemented in Rwanda, Burundi, and Zimbabwe also exposed the project team and the Bank to regional and international knowledge and experience. M&E was well designed, with appropriate outcome indicators and sound arrangements for carrying out a range of activities, through the RBF mechanisms and complemented with process and impact evaluations (see



Section 9a on M&E Design). Thanks to RBF mechanisms, especially the performance-based contracts, institutional arrangements were well articulated and appropriate. The project was prepared in just over a year, with the concept review held in February 2013 and Board approval in March 2014. The project was declared effective only two months later, an indicator of government readiness to implement.

Quality-at-Entry Rating

Satisfactory

b. Quality of supervision

The Bank's focus on development was proactive, as evidenced by the five restructurings undertaken during the project's life. These restructurings supported reallocations of project funding, changes/additions to project interventions (including two Additional Financings), and the fine-tuning of the results framework (especially clarification of indicator definitions and adjustments to baselines and targets), all with a view to boost and better document development outcomes. Bank supervision missions were carried out twice a year on a regular basis, and the field-based presence of most team members enabled close support and communication. Supervision reporting and aides-memoire were detailed and candid, focused on implementation challenges and how to address them. Supervision of fiduciary aspects was strong (see Section 10b). Supervision of health care waste management, however, was lacking in the early years of the project. While emphasized as important from the project's outset, no updates on the installation of incinerators were provided for several years, nor were they assessed at the mid-term review. In January 2019, a dedicated environmental mission carried out a thorough review and recommended actions that were undertaken during that year, leading to an upgrade in the environmental due diligence rating from Unsatisfactory to Satisfactory in December 2019.

While the supply- and demand-side RBF did not experience major delays, results data were not updated regularly. This issue was addressed, at the task team's recommendation, by the participation of project staff in trainings in Washington, DC, Canada, and Kenya. Although there were three task team leaders (TTLs) during project preparation and implementation, continuity was assured because the second TTL was part of the initial team, and the first TTL continued to be a task team member after the handover.

Quality of Supervision Rating

Satisfactory

Overall Bank Performance Rating

Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

Even though a theory of change or results chain was not required for inclusion in the PAD, the underlying project logic, as laid out in the original project components and captured in the ICR's Figure 1 (p. 9), was



clear and well founded. The design was oriented around three synergistic interventions that aimed, respectively, to: (1) increase demand for and uptake of maternal and child health and nutrition services and stimulate healthier behaviors and practices; (2) improve the quality and availability of priority health and nutrition services for mothers and children; and (3) strengthen and support a RBF management system to define, monitor, independently verify, and reward good performance across a range of project implementers through performance contracts with central-level institutions, regional health teams, and community groups and actors. All three interventions were mutually reinforcing and together supported well the PDO.

The PDO was well formulated, and PDO-level indicators and intermediate results indicators were adequate for tracking and evaluating achievement of the PDO. M&E plans focused on (i) monitoring of implementation and the use of information for corrective actions; (ii) tracking progress against outcome targets; and (iii) assessing impact on key health and nutrition outcomes. The RBF design encompassed both internal verification of service quantity and quality data (carried out, respectively, by the National Nutrition Agency and Regional Health teams) and external verification methods, including financial and quality audits at all operational levels carried out by an independent verification agency, and community verification of patients and patient satisfaction, carried out by contracted community-based organizations. Regional health teams were to monitor and supervise health facility and community activities, based on checklists to be developed under the project. The evaluation plan included both process and impact evaluations to support a learning process. The design also included a mixed-method impact evaluation that would be prospective, randomized, and controlled to the measurement of all impact attributable to the project.

b. M&E Implementation

During implementation, ongoing refinements of the results framework included: revision of indicator formulations and definitions; recalculation of baseline and resetting of endline values to reflect evolving data availability, expansion of coverage, and an effort to document baselines and trends for the five project regions, where available, instead of national averages; recategorization of intermediate results and outcome indicators; a move towards the use of project region data, where available, instead of national indicator formulation and definition. Household surveys provided a sound data source for tracking service delivery outcomes (series of Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS)). The HMIS, demographic health information system, and performance tracking under RBF contracts with health facilities, communities, and regional and central implementers all provided viable data sources to track implementation and intermediate results. The ICR noted (p. 25) that there was some fragmentation of reporting tools (paper-based maternal and child health registers and quality of care checklists), but this did not affect implementation. External verification of data was undertaken by an independent firm supported by an external consultant.

The M&E unit initially had only one staff (central M&E officer). Recruitment of four additional staff and the participation of two M&E staff from the National Nutrition Agency and one from the Ministry of Health received M&E training at World Bank headquarters in 2018. The impact evaluation provided



information on phase one health facilities and communities and provided course correction in subsequent phases.

c. M&E Utilization

Progress reports were prepared and disseminated on a quarterly basis. Their assessment of results, challenges, and recommendations to improve implementation and outcomes were a tool for informing actors and stakeholders about project performance and for taking decisions and actions to further enhance implementation and outcomes. Project infographic videos were also developed to share the experiences and lessons of the project. Data and processes inherent in the RBF mechanism ensured that individual contractors operating in communities (health centers and communities) were aware of their priority activities and performance goals and enhanced their focus on achieving them through regular tracking of indicators and payments for good performance.

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

The ICR indicated satisfactory compliance with the Bank's safeguard policies. The only policy triggered by the project was OP/BP 4.01 on Environmental Assessment. The project was assigned a Category B status because it did not involve any civil works or land acquisition. At the time of preparation, the Bank considered the implementing agencies to have necessary capacity to deal with the medical waste expected from the facilities to be supported under the project. A Health Care Waste Management Plan (HCWMP) satisfactory to the Bank was developed and disclosed in-country and at the Info-Shop in January 2014 (prior to effectiveness). A HCWM Policy and Standard Operating Procedures were also developed. While some HCWM materials (bags, dustbins, masks, and goggles) were procured, others (mercury spill clean-up kits) were not. The task team in a follow-up discussion (2-12-21) noted that this selectivity was based on priority-setting and relevance to the baselines and needs of individual facilities. The Bank's supervision of environmental aspects was weak in the project's early years, but picked up when an environmental expert mission was undertaken in January 2019 (see Section 8b.). This increased attention led to the installation of incinerators in 35 of 37 facilities in 2019. Of the two remaining facilities, one (Basse District Hospital in Upper River Region) was further delayed due to a change in the original site allocated by the hospital), and one (Kuntaur Health Center in Central River Region) was cancelled due to a high water table because of its proximity to a river.

Follow-up discussions with the task team revealed that the HCWM experience under the project culminated in lessons and opportunities for further improvements, which have been taken up under the follow-on projects (RBF and COVID). An Environmental Health Manager, working within the Ministry of Health, is assigned as the focal point for environmental safeguards, responsible for regular supervision of all related activities. Supervision of the operation of incinerators installed by the project has revealed opportunities to



further refine their effectiveness and to upgrade some of them, especially in densely populated areas, moving toward the introduction of cleaner, more efficient microwave technologies. Ongoing projects are also supporting the establishment of a clinical waste treatment center, designed and equipped to treat waste from a cluster of health facilities that would be transported by trucks procured with project funds. The team also clarified that the HCWM criteria included in the quality verification tool for health facilities did not cause undue pressure on these facilities or undermine their performance payments, since the delays in compliance were procurement-related and clearly beyond the mandates of health facilities to address.

While the project did not trigger any social safeguards, the ICR (p. 26) noted that certain social safeguard activities did take place. No explicit grievance redress mechanism was established at appraisal, but a community client tracing and satisfaction survey was conducted quarterly to monitor overall satisfaction with services. These surveys were used to verify the client's existence (traceability), confirm if services claimed to be provided by health facility were indeed offered, and measure satisfaction levels of sampled clients. Initial surveys, conducted by community-based organizations, were not submitted on time. Subsequent ones were carried out more reliably by health training institutions recruited by the project. These surveys revealed a high satisfaction rate across all health regions (98 percent or more), with minor issues associated with long wait times, unavailability of some prescriptions in the facility (causing the client to pay for them at other pharmacies), and poor attitude of some providers.

b. Fiduciary Compliance

Financial Management. The ICR (p. 27) indicated that financial management was carried out in accordance with the Bank's guidelines. The Project Operational Manual was kept current, and the interim unaudited financial reports were acceptable to the Bank. All of these reports were submitted on time, with one exception (delayed submission due to the project implementation committee's mission to Rwanda for South-South Learning Exchange). All external audits were unqualified, and their recommendations were implemented. Financial management capacity was strengthened for a broad range of project actors, including health facilities, communities, Regional Health Directorates, the Department of Community Development, Regional Agricultural Directorate, and Regional Department of Livestock Services. Separate financial management missions took place on a regular basis to ensure continued mitigation of risks.

Initial project implementation delays of 4-6 months did not affect project results. The project (and its multiple bank accounts and disbursement categories) experienced currency exchange losses. The clause in the legal agreement requiring the rollout of the Gambia Integrated Financial Management Information System was annulled due to unsatisfactory internet connectivity and other technical issues. These issues have since been addressed, and the system will be required for future Bank-financed projects.

Procurement. The ICR (p. 27) indicated that procurement was carried out in compliance with World Bank guidelines. The Systematic Tracking of Exchanges in Procurement was diligently employed by the project



in its implementation of the Procurement Plan. No mis-procurement was identified by procurement post reviews during the life of the project. Delays in installing incinerators in health facilities were caused mostly by an initial lack of World Bank supervision of environmental safeguards and the unavailability on the local market of the specialized material, which had to be procured internationally. Delays of about 18 months in the procurement of food and nutrition security inputs were due to gaps in capacity of the project implementation committee, which had never procured livestock through the World Bank system. The absence of a clause requiring the supplier to quarantine the livestock for 14 days, in accordance with general protocol, led to the death of approximately 400 animals during the first phase. The second phase procurement of livestock took this lesson into account by including a quarantine clause, and culminated in their successful acquisition and distribution. An alternative procurement arrangement was employed for the Ebola Virus Disease Preparedness and Control component, under which UN agencies carried out procurement on a single-source basis.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Highly Satisfactory	Highly Satisfactory	
Bank Performance	Satisfactory	Satisfactory	
Quality of M&E	Substantial	Substantial	
Quality of ICR	---	High	

12. Lessons

The following lessons are a subset of the nine relevant and insightful lessons presented in the ICR, slightly reworded by IEG to be more succinct:

Learning initiatives and solid analysis during preparation can be instrumental in improving project design and implementation. For this particular project, these included: a pre-pilot learning experience grant; participation of the project team in a South-South Learning Exchange to observe



RBF programs in Rwanda, Burundi, and Zimbabwe; and project preparation studies that established background and baselines for project development.

A RBF design can be both innovative and effective in its approach to supply- and demand-side interventions, which, in turn, serve to increase the utilization of maternal and child health and nutrition services. The project's piloting of community-based RBF was an important complement to supply-side RBF approaches aimed at improving the availability and quality of service delivery. Community-based RBF increased the use of preventive services (Vitamin A supplementation, deworming, antenatal care visits), improved health workers' responsiveness to communities, and raised the bar for greater involvement of communities in improving health and nutrition outcomes.

Strong government commitment to RBF is key to its successful implementation and sustainability. The approach required significant technical support and institutional arrangements that guided overall implementation. Two years before project closing, the Ministry of Finance and Economic Affairs, National Nutrition Agency, and Ministry of Health developed and launched implementation of a Sustainability Road Map (addressing financial, institutional, and operational sustainability), and allocated annual budgetary resources for 2019 and 2020.

Also key to the successful implementation of RBF is capacity strengthening at all levels: central, regional, and local levels. Training on RBF management, M&E, and other guidelines and policies equipped the project team, regional health directorates, and the Department of Community Development to encourage and oversee increased utilization of health services. Training of village development committees and village support groups enhanced their ability to mobilize community engagement, participation, and ownership, leading to changes in attitude, behaviors, and practices and an increased demand for health and nutrition services.

Paper-based health data management runs the risk of clerical data issues, which have repercussions for data accuracy and RBF operations and payments. Project experience points to opportunities to shift toward electronic systems to improve data collection and management and to facilitate data verification. There is also scope to digitalize the Quality of Care checklist and link it to the demographic and health information system.

A multi-sectoral approach is crucial to ensure better health and nutrition outcomes, but this requires additional support from other sectors. This holds especially true for the agricultural sector, given the food and nutrition security crisis and response that emerged during project implementation. South-South exchanges and learning visits could be relevant for inspiring better



cross-sectoral coordination and implementation, along with the development of clear roles and responsibilities for implementation.

IEG's review offers two additional lessons:

A well designed and implemented RBF approach can strengthen the quality and resilience of health and nutrition service provision, and achieve formidable results, even in the face of a difficult country context. This project was designed and implemented when The Gambia was facing many significant challenges: a coup d'état, presidential elections, poor economic performance causing hardships to households, erratic rainfall, and increasing food and nutrition insecurity. And yet, the project achieved a highly satisfactory outcome. Resilience to political changes can be attributed at least in part to the RBF approach and its disciplined focus on service quality. It set quality standards and enabled service providers to attain those standards through its payments for performance. This gave providers the liquidity, flexibility, and incentive to maintain and further improve that quality during a period of political change and uncertainty. It also earned the strong appreciation and support of communities, who voiced their desire with the new administration (during its initial field visits) to maintain this approach post-project. Moreover, the strong results focus of RBF triggered project restructuring and additional financing, designed to ensure the achievement of the PDO in light of heightened vulnerabilities in the country due to increasing poverty and food and nutrition insecurity.

A strong results focus throughout implementation, characterized by the continued updating of resources, interventions, and results framework in response to emerging challenges and opportunities, is likely to enhance project performance and outcomes. The Bank's team was proactive in refining many aspects of project design, financing, and outcome measurement, undertaken during the course of five restructurings and including two Additional Financings. These efforts, harmonized with RBF performance indicators in supply-side, demand-side, and administrative contracts, kept all actors focused on the monitoring and achievement of the PDO.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

Quality of Evidence and Results Orientation. The ICR had a strong results orientation. The evidence was of good and reliable quality. Most of the baselines and results on outcome indicators were drawn from viable household surveys (DHS and MICS), calculated for the five project regions when regional breakdown of data made it possible. Some of the intermediate results indicators were reported on the basis of data generated by



health information systems and community registers. Outcomes and intermediate outcome data were corroborated and complemented by an impact evaluation.

Quality of Analysis. The analysis was well grounded in the solid results chain, linking inputs, outputs, intermediate outcomes and outcomes, drawing on and triangulating data from different sources and studies. The analysis also plausibly linked the RBF implementation arrangements and other factors to the project's performance and outcome. Annex 8 of the ICR provided a helpful overview of the many changes to the results framework over time (recalculated baselines and targets, changed indicator definitions, changed categories of indicators, additions and dropping of indicators). However, there were minor inconsistencies in baselines and targets between Annexes (Results Framework and Key Outputs), and Annex 8 did not capture all changes in targets across the project timeline. The ICR explored aspects of attribution through its sound analysis of a strong results chain and an overview of donor support, characterized by the small number of donors supporting health in The Gambia, their emphasis on policy work, and -- where there was overlap with the project -- the very small scale of other donors' interventions. While the ICR did not explore the counterfactual in the efficacy section, the task team offered a rich array of insights on the counterfactual of no project during a follow-up discussion with IEG (2-12-21), drawing on insights from a thorough and thoughtful ICR.

Quality of Lessons. Lessons were insightful and well grounded in evidence and analysis, likely to be of relevance to other countries aiming to improve maternal and child health and nutrition.

Internal Consistency. The ICR was internally consistent. One small exception was on page 2, which presented the original project cost as \$21.18 million instead of the original estimate of \$8.68 million, net of the two Additional Financings.

a. Quality of ICR Rating
High