Gambia - Participatory Health Population and Nutrition Project

Country:	Gambia, The ;	**Credit No:**	3054 ; P823
Document Date:	2006/05/22	**Doc Name:**	Gambia - Participatory Health Population and Project
Document Type:	Implementation Completion and Results Report	**Language:**	English
Major Sector:	Public Administration, Law, and Justice ; Health and other social services	**Rel. Proj ID:**	GM-Part. Health/Pop./Nut. -- P000825 ;
Region:	Africa	**Rep Title:**	Gambia - Participatory Health Population and Project
Report Number:	35610	**Sector:**	Central government administration ; Health
SubTopics:	Health Monitoring & Evaluation ; Adolescent Health ; Rural Development Knowledge & Information Systems ; Agricultural Knowledge & Information Systems ; Early Child and Children's Health	**Topics:**	Agriculture ; Health, Nutrition and Population Development
TF No/Name:	TF037250-AFRICA REGION - HEALTH PROJECTS (GAMBIA - PARTICIPATORY HEALTH, ; TF029427-PHRD-PARTICIP. POPULATION, HEALTH & NUTRITION ; TF036347-GAMBIA - PARTICIPATORY HEALTH, POPULATION AND NUTRITION ; TF035907-THE GAMBIA - PARTICIPATORY HEALTH, POPULATION AND NUTRITION PROJ ; TF035741-GAMBIA - PARTICIPATORY HEALTH, POPULATION AND NUTRITION	**Unit Owning:**	AFT: Human Development 2 (AFTH2)
Volume No:	1 of 1		

Abstract: The outcome for the Participatory Health Population and Nutrition Project for Gambia was satisfactory, the sustainability was unlikely, the institutional development impact was modest, and the Bank and borrower performance were both satisfactory. Lessons learned from the project: In the view of the ICR team and the quality enhancement review panel members, the Participatory Health Population and Nutrition Project's (PHPNP's) scope, content, and design were too ambitious, complex and demanding given the weak implementation capacity of the Department of State for Health. Monitoring and evaluation system for tracking key performance indicators should be put in place at the onset and maintain during the project life and beyond. Country-specific context should be seriously considered when importing best practice from another country. The success of the nutrition component in this project was undoubtedly linked to the excellent leadership of National Nutrition Agency's director.

Keywords:
http://www-wds.worldbank.org/servlet/main?menuPK=64187510&pagePK=64193027&piPK=64187937&theSitePK=523679&entityID=000090341_20060607104525

Document of
The World Bank

Report No: 35610

IMPLEMENTATION COMPLETION REPORT
(PPFI-P8230 PPFI-P8231 TF-29427 IDA-30540)

ON A

CREDIT

IN THE AMOUNT OF SDR 13.4 MILLION (US$ 18 MILLION EQUIVALENT)

TO THE REPUBLIC OF

THE GAMBIA

FOR A

PARTICIPATORY HEALTH POPULATION AND NUTRITION PROJECT

May 22, 2006

CURRENCY EQUIVALENTS

(Exchange Rate Effective 1998)

Currency Unit = Dalasi
D1 = US$ 0.094
US$ 1 = D10.58

FISCAL YEAR
January 1   December 31

ABBREVIATIONS AND ACRONYMS

AfDB	African Development Bank
BFCI	Baby Friendly Community Initiative
BHF	Basic Health Facility
BI	Bamako Initiative
CAS	Country Assistance Strategy
CBGM	Community Based Growth Monitoring
CHN	Community Health Nurse
CRD	Central River Division
DCA	Development Credit Agreement
DHT	Divisional Health Team
DoSH	Department of State for Health
DPI	Directorate of Planning and Information
DSH	Directorate of Health Services
FGM	Female Genital Mutilation
FOO	Field Operation Officer
FPRI	Food Policy Research Institute
GAFNA	Gambia Food and Nutrition Policy
GOTG	Government of The Gambia
GSMMP	Gambia Social Marketing Management Program
HEU	Health Education Unit
HMIS	Health Management Information System
HPTG	Health and Poverty in The Gambia
IDB	Islamic Development Bank
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
KMC	Kaniffing Municipal Council
KPI	Key Performance Indicators
LIF	Local Initiative Fund
LRD	Lower River Division
MCH	Maternal and Child Health
MDFT	Multi-Disciplinary Facilitation Teams

MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MTR	Midterm Review
MUAC	Mid-Upper Arm Circumference
NaNA	National Nutrition Agency
NBD	North Bank Division
NHDP	National Health Development Plan
NNPC	National Nutrition Policy Council

NRD	Northern River Division
PAD	Project Appraisal Document
PCC	Project Coordination Committee
PDOs	Project Development Objectives
PHC	Primary Health Care
PHPNP	Participatory Health Population and Nutrition Project
PIU	Project Implementation Unit
PPF	Project Preparation Facility
PSR	Project Status Report
QAG	Quality Assurance Group
QER	Quality Enhancement Review
RfH	Riders for Health
SEN	State Enrolled Nurse
SRN	State Registered Nurse
STIs	Sexually Transmitted Infections
SW	South West
TBA	Traditional Birth Attendants
TFR	Total Fertility Rate
UNICEF	United Nations Children Fund
URD	Upper River Division
VHWs	Village Health Workers
VSGs	Village Support Groups
WHO	World Health Organization

Vice President:	Gobind T. Nankani
Country Director	Madani M. Tall
Acting Sector Manager	William Experton
Task Team Leader:	Gaston Sorgho

GAMBIA, THE
Participatory Health, Population and Nutrition Project

CONTENTS

Page No.

1. Project Data 1
2. Principal Performance Ratings 1
3. Assessment of Development Objective and Design, and of Quality at Entry 2

4. Achievement of Objective and Outputs
6
5. Major Factors Affecting Implementation and Outcome
14
6. Sustainability
16
7. Bank and Borrower Performance
16
8. Lessons Learned
18
9. Partner Comments
19
10. Additional Information
19
Annex 1. Key Performance Indicators/Log Frame Matrix
20
Annex 2. Project Costs and Financing
22
Annex 3. Economic Costs and Benefits
25
Annex 4. Bank Inputs
26
Annex 5. Ratings for Achievement of Objectives/Outputs of Components
29
Annex 6. Ratings of Bank and Borrower Performance
30
Annex 7. List of Supporting Documents
31
Annex 8. Riders for Health Contract Execution
33
Annex 9. Background Information on the Country
34
MAP IBRD 33409

Project ID: P000825
Project Name: Part. Health/Pop./Nut.
Team Leader: Gaston Sorgho TL
Unit: AFTH2
ICR Type: Core ICR
Report Date: May 22, 2006

1. Project Data

Name: Part. Health/Pop./Nut.
L/C/TF Number: PPFI-P8230; PPFI-P8231;

TF-29427; IDA-30540
Country/Department: THE GAMBIA
Region: Africa Regional Office

Sector/subsector: Health (99%); Central government administration (1%)
Theme: Population and reproductive health (P); Child health (S); HIV/AIDS (S); Nutrition and food security (S); Gender (S)

KEY DATES
Original Revised/Actual
PCD: 03/03/1994
Effective: 06/30/1998 08/13/1998
Appraisal: 10/29/1997 MTR:
03/11/2002 03/11/2002
Approval: 03/31/1998
Closing: 12/31/2003 06/30/2005

Borrower/Implementing Agency: GOV'T OF GAMBIA/MIN OF HEALTH
Other Partners:

STAFF Current
At Appraisal
Vice President: Gobind T. Nankani
Jean-Louis Sarbib
Country Director: Madani M. Tall
Mahmood A. Ayub
Sector Manager: William Experton
Nicholas Burnett
Team Leader at ICR: Gaston Sorgho
Richard Seifman
ICR Primary Author: Gaston Sorgho; Kofi Amponsah

2. Principal Performance Ratings

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HL=Highly Likely, L=Likely, UN=Unlikely, HUN=Highly Unlikely,
HU=Highly Unsatisfactory, H=High, SU=Substantial, M=Modest, N=Negligible)

Outcome: S
Sustainability: UN
Institutional Development Impact: M
Bank Performance: S
Borrower Performance: S

QAG (if available) ICR
Quality at Entry:
U
Project at Risk at Any Time: Yes

3. Assessment of Development Objective and Design, and of Quality at Entry

3.1 Original Objective:
The overall development objective of the Participatory Health Population and Nutrition Project
(PHPNP) was to improve family health--defined as a combination of reproductive health, infant

and child health and good nutritional status. The project was designed as a sector investment
program targeting primary and secondary health care and both rural and periurban areas.

The PHPNP's objectives were pertinent to and consistent with the overall objective of the
Country Assistance Strategy (CAS) for The Gambia of improving the quality of life for the
Gambian population. They were also pertinent to and consistent with the Government of The
Gambia's (GoTG) health sector priorities set forth in the "Health Policy 1994�2000: Improving
Quality and Access" document. Because of the multitude of significant health issues afflicting the
population--including human resources limitations and high maternal, infant, and child morbidity
and mortality--and the limited capacity of The Gambia's health sector to adequately plan,
manage, coordinate, monitor, and evaluate services as outlined in the Project Appraisal Document
(PAD), the project objectives were difficult to achieve fully.

3.2 Revised Objective:
The objective was not revised.

3.3 Original Components:
The PHPNP consisted of four main components. As discussed below, Component 1 focused on
improving coverage and quality of reproductive health services; Component 2 aimed at
integrading management of childhood illness; Component 3 focused on improving nutrition
services for women of reproductive age, infants and children; and Component 4 aimed at
improving the management and implementation of the family heath program. These components
are described as follows (figures in parenthesis are the estimated costs at appraisal, including
contingencies):

Component 1: Reproductive Health Services (US$ 4.7m)
The reproductive health services component of the PHPNP had three subcomponents: (1)
maternal health services; (2) prevention and management of unwanted pregnancies; and (3)
prevention and control of sexually transmitted infections (STIs) and human immunodeficiency
virus/acquired immune deficiency syndrome (HIV/AIDS).

Subcomponent 1: Maternal Health Services (US$ 1.8m)
This subcomponent was intended to: (1) improve the coverage and quality of maternal health
services through: (a) the provision of training for staff of health facilities, traditional birth

attendants and community health nurses; (b) the revision of midwifery schools' curricula and of
training curricula for basic health facility staff, community health nurses and traditional birth
attendants; (c) the revision of clinical practice and supervision guidelines; (d) the identification and
implementation of appropriate means of transport for obstetrical emergencies; (e) the expansion
and strengthening of postpartum home visits; and (f) the acquisition of equipment and supplies to
health facilities; (2) increase utilization of maternal health service by conducting: (a) client
satisfaction surveys; and
(b) information, education, and communication (IEC) campaigns directed towards women of

reproductive age, their families and communities; (3) increase awareness and promoting
attitudinal changes towards female genital mutilation, through community-based IEC campaigns
directed towards women of reproductive age, older women and men, and community and
religious leaders; and (4) increase knowledge about the factors contributing to maternal mortality,
through carrying out audits on maternal death occuring in health facilities and in the communities.

Subcomponent 2: Prevention of Unwanted Pregnancies (US$ 2.3m)
This subcomponent was intended to: (1) increase the demand for family planning services and
contraception through IEC and social marketing directed towards men and women
of reproductive age and older women and men, community and religious leaders; and (2) increase
the acquisition and supply of contraceptives through Social Marketing.

Subcomponent 3: Prevention and Control of STIs and HIV/AIDS (US$ 0.6m)
The subcomponent of the prevention and control of STIs and HIV/AIDS was intended to do the
following: (1) increase knowledge about STIs and HIV, preventive practices, and encourage
healthy behavior for treatment of STIs through IEC directed toward women and men of
reproductive age, their families and communities; and (2) improve the diagnosis and treatment
of STIs through: (a) completion of training curriculum on syndromic management; (b) provision
of clinical in-service training for health providers of syndromic management; (c) development
of clinical practice guideline; (d) revision of nurse and midwifery curricula to include syndromic
management of STIs; (e) introduction of paternal screening of women for STIs, and

(f) acquisition of equipment and supplies for testing for STIs and drugs for treatment.

Component 2: Integrated Management of Childhood Illness (IMCI) (US$ 0.9m)
The PHPNP's second component aimed at supporting the introduction and implementation of
IMCI in the Gambia. This goal was to be achieved through: (a) training of core facilitators;
(b) carrying out surveys to assess infant and child health situation; (c) carrying out a national
IMCI orientation workshop; (d) establishing an IMCI taskforce; (e) developing a preparation
plan;
(f) adaptating the generic IMCI materials to The Gambian's context; (g) producing diagnostic and
therapeutic materials for health workers; (h) pretesting and disseminating IMCI materials;
(i) training the trainers; (j) training health workers in the implementation and supervision of IMCI;
(k) revising pre-service training curricula; (l) carrying out an IEC campaign oriented towards
parents; (m) ensuring continuous monitoring and evaluation, supervision, operations, research and
technical studies in support of the above, including capacity surveys.

Component 3: Nutrition Policy and Services for Women, Infants and Children (US$ 2.3m)
The PHPNP's third component, on nutrition policy and services for women, infants, and children,
had two subcomponents: (1) to strengthen nutrition policy formulation and institutions;
and (2) to encourage the use of community and micronutrient approaches to improve the
nutritional status of women and young children.

Subcomponent 1: Nutrition Policy Formulation and Institutional Strengthening (US$ 0.8m)
The subcomponent supported the : (1) preparation and adoption of a national nutrition policy
and action plan for its implementation through the provision of technical advisory services and
acquisition of goods, for continuing intersectoral coordination in the field of nutrition; (2)
implementation of an IMCI strategy to create awareness about nutrition among policy makers and
the general public; (3) design and implementation of a training program for policy and program
analysis, information collection, and appropriate interventions in the field of nutrition; and
(4) development and implementation of an improved anthropometric data collection survey

system.

Subcomponent 2: Community and Micronutrient Approaches to Improve the Nutrition Status of Women and Young Children (US$ 1.5m)

The subcomponent was intended to: (1) develop and implement a nutrition education strategy through (a) the provision of technical advisory services to assess and redesign field level nutritional education activities; and (b) the training of village-based volunteers as peer counselors and the training of community health nurses and traditional birth attendants in implementing nutrition education activities; (2) carry out surveys to assess maternal food supplementation programs; (3) test and evaluate a pilot program to provide food supplements and to increase communities' self-sufficiency; (4) review and refine strategies to address micronutrient malnutrition; carrying out a training program for field staff for the aforementioned activities; (5) develop and generate materials for an IEC campaign for the prevention and control of micronutrient deficiencies; and (6) acquire equipment and vehicles for Directorate of Health Services Nutrition Unit.

Component 4: Management and implementation of a Family Health Program (US$ 10.7m)

The fourth component consisted of four subcomponents: (1) capacity building and policy development; (2) upgrading and maintenance of health infrastructure; (3) establishment of a local initiative fund (LIF); and (4) project management.

Subcomponent 1: Capacity Building and Policy Development (US$ 2.8m)

The subcomponent was intended to: (a) expand the Bamako Initiative; (b) coordinate IEC activities; (c) develop a comprehensive health management information system (HMIS); (d) develop health mapping capacity; (e) strengthen capacity in the area of applied research; (f) develop a staff retention strategy and regular staff surveys; (g) develop health financing policy; (h) update and partially implement the National Drug Action Program; and (i) develop a maintenance policy for The Gambia's health facilities.

Subcomponent 2: Upgrading and Maintenance of Health Infrastructure (US$ 6.0m)

The subcomponent was to provide support for (a) construction, rehabilitation, and refurbishing of a selected number of health infrastructure facilities, including dispensaries, staff quarters, and limited refurbishment of surgery theaters; (b) maintenance of health facilities, building, equipment,

and vehicles; (c) acquisition of medical equipment and supplies, and office equipment; and
(d) increasing the supply of blood through blood-donor mobilization.

Subcomponent 3: Local Initiative Fund (LIF) (US$ 0.9m)
The LIF subcomponent was to provide support for (a) the provision of grants for the financing of
activities in the area of reproductive health, infant and child health and nutrition; (b) the
strengthening of the administrative and operational capacities of the LIF; (c) developing and
implementing an information, education and communication strategy for LIF; and (d) monitoring
and supervising the field activities financed by the LIF.

Subcomponent 4: Project management (US$ 1.0m)
The project management subcomponent was intended to provide institutional support,
management and coordination of activities of the aforementioned components, through the
establishment of a Project Implementation Unit (PIU). The PIU was to receive guidance and
support from a Project Coordination Committee and the PHPNP Action Group. It was also meant
to coordinate the health sector activities financed by the African Development Bank (AfDB) and
the Islamic Development Bank (IDB). Specifically, the PIU had the following responsibilities:
(a) the management of project funds; (b) the procurement of goods and services; (c) the
installation and maintenance of sound financing and accounting procedures for all funds;
(d) the preparation and dissemination of progress report; (f) organizing the joint GoTG-IDA
annual reviews and midterm review; (g) coordination of all training, monitoring and evaluation
activities, and compiling all results in comprehensive progress reports for review during annual
reviews; and (h) supervision of the activities of a PHPNP nutrition coordinator and of a PHPNP
IEC coordinator.

Overall, the four components were in line with the PHPNP's development objectives and the CAS
for The Gambia. The design of the components was very comprehensive, covering every area of
the health system in The Gambia, except the national hospitals. However, given the weak
capacity of the country's Department of State for Health (DoSH), the content of these
components were overly ambitious.

3.4 Revised Components:
The Quality Enhancement Review (QER) Panel's report of October 2001 suggested that the
project be restructured in view of the unsatisfactory progress in implementation and the slow rate
of disbursement. The QER panel recommended that the midterm review (March 2002) be used as
an opportunity to inject a needed degree of realism into this ambitious project. It urged the
midterm review task team to be realistic about what could be achieved during the remaining life of
the project and, as such, identify areas that could be cancelled.

Although the midterm review team found that a large number of components and subcomponents
of the PHPNP were not being implemented as anticipated, the team decided to keep project's
content as designed. However, a reorganization of some components took place. IEC activities
found in the various components were merged into one subcomponent of Component 4. That
component was expanded to include new activities, notably the financing of a U.K. group called
Riders for Health (see Annex 8) to conduct the maintenance program.

The PHPNP's performance improved considerably in terms of disbursement by the first quarter
after the March 2002 midterm review. Then the project was extended by 18 months from

December 31, 2003, to June 30, 2005, with the aim of meeting the project development
objectives.

3.5 Quality at Entry:
Overall, the quality at entry is rated marginally unsatisfactory. The four components and nine
subcomponents of the project were designed with no prioritization to guide implementation. The
2001 QER panel assessed the PHPNP's scope and content and pointed out that the project
development objectives were too ambitious and the project design too complex and demanding.
Clearly, such an ambitious and complex project was inappropriate for a country such as The
Gambia with very low implementation capacity. The fact that the project did not set up an
adequate monitoring and evaluation framework is another reason for the marginally unsatisfactory
rating at entry.

The objective of the PHPNP was relevant to the CAS for The Gambia and to the GoTG's health
sector priorities. It was also relevant to the country assistance interim strategy of supporting
poverty alleviation through investments in the health and education sectors. However, at the time
of project's preparation, the issue of health sector human resource and management was not
properly addressed as a major concern. The project appraisal team recognized the situation in the
risk section; however, the appraisal could have included a sound assessment of the institutional
capacity of The Gambian Department of State for Health (DoSH) to carry out such project and
bring about relevant measures within the sector to ease the implementation.

Notwithstanding the overall rating, the preparation team should be commended for the
participatory approach used for designing the project. The project design benefited from the
lessons learned from the National Health Development Project completed in June 1995 and
incorporated successful elements from the Women-in-Development Project. To that extent, the
GoTG and the Bank gathered information on beneficiary (community and health workers)
perspectives through surveys, including focus group discussion. A five-day workshop was
organized with key stakeholders (central and local governments, divisional health teams,
nongovernmental organizations, research institutes, U.N. agencies and other organizations) to
design the project. The preparation team worked in close collaboration with members of the
PHPNP Coordination Committee in The Gambia to prepare detailed implementation plans and
timelines for project activities and to consult with other donors with regard to their prospective
contributions to the sector.

4. Achievement of Objective and Outputs

4.1 Outcome/achievement of objective:

The outcome of the PHPNP is rated marginally satisfactory, because the fertility rate in The
Gambia declined from 6.4 to 5.1 children per woman, and child malnutrition was reduced by more
than 25 percent. The project outcome could not be rated fully satisfactory, because although the
infant mortality rate in the country declined from 92 to 75 deaths per 1,000 births, it did not reach
the appraisal target of 65 per 1,000 births. Data on STI prevalence rates are unavailable.

Having said that, the team would like to make two points before going into the detail of the

project achievements. First, there is no causal relationship between the improvement of the
outcome indicators and the project outputs. The decline in infant mortality cannot be attributed
to improvement in nutritional status of children, nor can the decline in fertility be attributed to any
successful five-year family planning program. Second, the project lacks basic quantitative output
and outcome data. Studies planned to provide specific information were not executed. As a
result, the ICR team had to gather proxy indicators from various source of information to make
its judgment; sometimes, the team just could not find the necessary proxy indicator to compare to
the project target

Improvements achieved due to the project are in line with the emphasis given on primary and
secondary levels of health services. This project represented a significant increase in terms of the
size, scope, and donor financing of primary and secondary care in The Gambia as compared to the
previous GoTG's emphasis on seeking donor financing principally for construction of major health
centers, and tertiary support. The ICR team is of the view that the intensive promotion of family
planning methods, including the social marketing of condoms (in 2004 and 2005) may have added
to the declining trend of fertility rate recorded in 2003 Census. The adoption and effective
implementation of the national nutrition policy; the establishment of a National Nutrition Agency
(NaNA); and the successful implementation of nutrition activities in communities contributed to
the improvement in children nutrition status. Even if the end of project target was not achieved,
the situation of infant mortality is consistently improving in The Gambia. As reported by the
United Nations Children's Fund (UNICEF), children immunization coverage is over 90 percent,
which is high performance.

Details of the ICR team's evaluation of project outcome indicators are provided below.
Additional information about key performance indicators is presented in Annex 1.
--Key Performance Indicator 1--Total Fertility Rate. Progress with respect to this indicator is
rated satisfactory. At the inception of the PHPNP, it was estimated that the total fertility rate in
The Gambia would be reduced by 10 percent--from a baseline figure of 6.4 children per woman

(meaning a reduction to 5.8 children per woman)--throughout the life span of the project. A 2005
World Bank report fixed the total fertility rate in The Gambia over the period 2000�2005 at 5.1
children per woman, slightly better than the Sub-Saharan African rate of 5.3 children per woman.
This fertility rate in The Gambia is confirmed by an analysis of the 2003 Census data that indicates
that higher female education levels and the delay in the age of marriage of younger cohorts of
women may have led to the observed decline of fertility. Various other factors contributing to the
significant improvement in the fertility rate in The Gambia include the PHPNP's family planning
program and its intensive social marketing of condoms and oral contraceptives undertaken
throughout the country.

--Key Performance Indicator 2--Reduction in the Infant Mortality Rate. Progress with
respect to this indicator is rated marginally satisfactory. The infant mortality rate in The Gambia
was reported as 84 infant deaths per 1,000 live births after the 2002 midterm review, a slight
improvement from the baseline rate of 92 infant deaths per 1,000 live births. Available statistics
from the 2003 Census suggested an infant mortality rate of 75 infant deaths per 1,000 live births;
however, a recent publication on "Health and Poverty Reduction in the Gambia" fixed the rate at
70 infant deaths per 1,000 live births recorded between the period 2000�2005. There has been an

improvement of The Gambia's infant mortality rate over time, but the end of project target of 65
infant deaths per 1,000 live births was not achieved.

--Key Performance Indicator 3--Reduction in Sexually Transmitted Infections (STIs). The
ICR team could not rate the progress on this indicator. The baseline indicator was issued from a
specific survey conducted in 1994. The target for this project development objective was to
reduce the prevalence of STIs among pregnant women by 50 percent at the end of the project.
The baseline was 25 percent prevalence of STIs among pregnant women in a 1994 Rapid
Assessment Survey. Available data show that the incidence among males and females who
experienced abnormal genital discharge was reduced by 5.8 percent in 2002 and 3.3 percent in

2005 while reported cases of genital ulcers were reduced by 3.3 percent and 1.4 percent,
respectively. The ICR team could not find any data on the prevalence of STIs among pregnant
women in the last three years.

--Key Performance Indicator 4--Reduction of Child Malnutrition Rate by 25 Percent. This
indicator is rated highly satisfactory. At the beginning of the PHPNP, 26 percent of children under
age five in The Gambia were underweight. Results from a survey conducted by NaNA at the end
of project found that 18.8 percent of children were underweight, indicating a reduction of 27.8
percent over the life of the project. Detailed analysis showed that stunting decreased in the
country from 23 percent in 1996 to 19 percent in 2000 to the current figure of 17.8 percent.
Earlier figures indicate that stunting was more than 30 percent in The Gambia. The findings of
NaNA's survey are consistent with the World Health Organization's Global Database information
on The Gambia.

4.2 Outputs by components:
Of the four components of the PHPNP, the nutrition policy and services for women, infants, and
children component (Component 3) had by far the greatest success. It progressed well and
produced all expected results. The reproductive health services component (Component 1),
particularly the maternal health and the prevention of unwanted pregnancies subcomponent, also
successfully carried out its major activities and led to the achievement of the contraceptive
coverage as planned at appraisal.

The other two components--integrated management of childhood illness (Component 2) and the
management and implementation of family health program (Component 4)--lagged behind.
Though the development of new policies was launched, which improved the health sector
strategy, the capacity building component suffered from high turnover of project management
staff and cabinet level overseers and some degree of resistance to hiring required short-term
external consultants. The implementation of a sophisticated health management information
system (HMIS) was also disappointing. Despite progress in developing indicators in a very
participatory manner, a paucity of concrete information made it difficult to assess progress.

Finally, it should be mentioned that no remarkable achievements were obtained prior to the

midterm review in March 2002. All progress was achieved subsequent to that review. The
following gives the rationale for the attributed rating to each of the component and
sub-component. Figures in parenthesis are actual costs.

Rating of Component 1: Reproductive Health Services. The overall rating for the reproductive
health component of the PHPNP is marginally satisfactory because the first and the second
subcomponents are marginally satisfactory while the third subcomponents is rated marginally
unsatisfactory.

--Subcomponent 1: Maternal Health Service (US$ 1.5m). This subcomponent is rated
marginally satisfactory. The project carried out the majority of activities under this subcomponent
but very little information is available to show the effect of those activities on the targeted
population. Antenatal care services with skilled attendant are on the increase nationwide, but the
proportion of women who completed the required number of three prenatal visits and the quality
or outcomes of the visits are not documented. The baseline (1998) for births attended by skilled
health workers is not known. It was estimated to be 44 percent in 1990. The project targeted 69
percent of deliveries to be carried out by skilled personnel. A recent survey conducted by the
National Nutrition Agency (NaNA) in The Gambia shows that up to 57 percent of births were
delivered in a health facility, which could be assumed to be the proportion of births attended by
skilled health workers. About 25 percent of total births took place at home with the assistance of
a traditional birth attendant but this proportion is not included in the indicator. According to
WHO defintion, Traditional birth attendants (TBA) either trained or not, are excluded from the
category of skilled health workers.

--Subcomponent 2: Prevention and Management of Unwanted Pregnancies (US$ 21m).This
subcomponent is rated marginally satisfactory. Contraceptive prevalence at baseline was 14
percent (1998) and the end of project target was 22 percent. Prevalence increased slightly to 15.1
percent for modern methods at midterm review in 2002. Current figure is not known, but the
World Development Report 2005 projected that contraceptive prevalence for modern methods is

18 percent for The Gambia. This is a significant achievement despite the fact that the target was
not met. Using social marketing techniques, The Gambia's Social Marketing Program
implemented the distribution and supply of condoms and oral contraceptive pills throughout the
country. In spite of initial problems, which resulted in the replacement of the field operation
officer, the primary activity of ensuring a continuous supply of contraceptives seemed to have
been realized. The number of outlets served and provided with "COOL condoms" and "Kairo OC
pills," for example, was reported as 302 countrywide without any reference point. The number of
condoms and oral contraceptive pills sold by end of project was 550,800 pieces and 73,260 pieces
respectively--seemingly a fairly large number for a population of less than 1.5 million.

--Subcomponent 3: Prevention and Control of STIs and HIV (US$ 1.0m).This subcomponent
is rated marginally unsatisfactory. The focus of the subcomponent was to support the syndromic
management approach whose strategy was detailed in the project. The major activities such as
yearly provision of pharmaceuticals, development of clinical supervision system were not realized.
Inadequate supply of drugs at health facility levels reported in 2002 persisted until end of project.
A major setback of the STIs program was therefore the provision and management of STI drugs,
which is key to any program of syndromic management of STIs. Notwithstanding these issues, the
satisfactory promotion of condoms in The Gambia has contributed to improved STI prevention:
65.5 percent of sexually active men and 40 percent of sexually active women reported using a

condom in the last sexual contact with irregular partners (Behavior Sentinel Survey, 2005). The
PHPNP implemented activities related to production of diagnosis and treatment documents for
STIs, training of health personnel, private pharmacists as well as community level HIV/AIDS
counselors. The project was also instrumental in developing the HIV/AIDS institutions in The
Gambia, namely the National AIDS Commission and the National AIDS Secretariat. More
directly, the project contributed to the preparation and to some extent the implementation of the
country's HIV/AIDS Rapid Response Plan.

Rating of Component 2: Integrated Management of Childhood Illness (IMCI) (US$ 1.2m).
The ICMI component of the PHPNP is rated unsatisfactory. There is no reliable indicator for (a)
availability of IMCI diagnostic tools and treatment protocols in the basic health facilities, and (b)
the extent of the use of such tools by the village health workers. Moreover, the review of the
initial strategic plan for the design of IMCI implementation procedures was not completed.
Finally, the scaling up of the strategy by other partners such as the World Health Organization
was not as effective as expected.

The project could not achieve its overall aim of curbing the behavior of the population with
respect to delays in care-seeking due to traditional attitudes, beliefs about factors that cause
diseases, referral mobility problems, limited involvement of fathers in facilitating child referrals.
Nevertheless, through this component, the DoSH conducted a national IMCI orientation
workshop that led to the establishment of an IMCI Taskforce and the adaptation of generic IMCI
material to the conditions of The Gambia. Various training sessions (training of core facilitators,
training of private practitioners, degree training for three staff, training of community) and the
revision of curriculum for all nurse training institutions were completed. However, these activities
have very limited impact on the behavior of the population that is rooted into tradition and
cultural beliefs.

Rating of Component 3: Nutrition Policy and Services for Women, Infants and Children.
The nutrition component of the PHPNP is rated highly satisfactory. This component successfully
achieved all its key performance indicators and has had a significant institutional impact in The
Gambia.
--Subcomponent 1: Nutrition Policy Formulation and Institutional Strengthening (US$
1.5m).This subcomponent is rated highly satisfactory. The following activities were completed
under this subcomponent: development and printing of nutrition materials, equipment and
vehicles for NaNA, and succesful implementation of a local and international training program
that strengthened NaNA staff capacity. This program immensely contributed to high staff
retention. A national nutrition policy was formulated and adopted and a national Nutrition
Council chaired by the vice-president and comprising secretaries of state from various sectors was
established. In fact, the project's support to the nutrition, and good leadership of the manager of

the nutrition unit led to the GoTG's recognition of nutrition as a cross-cutting development issue rather than a sectoral issue. This translated into the creation of the NaNA under the office of the vice-president. Currently, NaNA benefits from a budget line item within the national budget structure at the same level as any ministry.

--Subcomponent 2: Community and Micronutrient Approach (US$ 0.4m).This subcomponent is rated satisfactory. The subcomponent supported and strengthened community based health and nutrition activities. IEC materials were developed and printed. Several IEC awareness campaigns were organized; divisional levels and institutional mechanisms to manage nutrition interventions at various levels were strengthened; and rehabilitation of malnourished children at health facility and community levels were carried out. A national survey conducted in May 2005 to assess the component's achievements, showed that 48.6 percent of children under four months of age were exclusively breastfed, indicating an improvement over the 36 percent reported in the Multiple Indicator Cluster Survey (MICS) of 2000. This figure exceeded the end of project target of 40 percent. Through this Baby-Friendly Community Initiative, the project provided support to the communities to implement the environmental sanitation program; to improve quality of foods during weaning (using dried moringa olifera leaf powder and the traditional method of fermentation). Also, the initiative succeeded in scaling up the BFCI activities in 263 communities, an improvement over the 12 communities piloted in the Lower River Division before the advent of PHPNP.

Despite these impressive results, the following activities, which were critical for monitoring and evaluation of nutrition program impact, were not implemented: (a) evaluation and designation of baby-friendly communities and recording of birth weights; (b) the training and certification of community representatives as Village Support Groups in 250 primary health care villages; (c) the construction of baby-friendly rest houses at the fields for lactating mothers; and (d) the creation and maintenance of a data bank for all communities participating in the Baby-Friendly Community Initiative.

Rating of Component 4: Management and Implementation of Family Health Program.
The family health component of the PHPNP is rated marginally satisfactory. Although the subcomponent on capacity building and policy development did not achieve enough to be rated satisfactory, the other three subcomponents achieved their objectives with a few shortcomings.

--Subcomponent 1: Capacity Building and Policy Development (US$ 2.8m).This subcomponent is rated marginally unsatisfactory. Two major policy reforms initiated under this component, the Bamako Initiative and the development of the health financing policy, did not yield concrete results. The health financing policy never took off and the Bamako Initiative ended at the pilot stage. Other significant health policy measures that were not developed included the production of National Health Accounts, the review of essential care package for cost-effectiveness, norms and standards, service delivery; the development of guidelines for the establishment of comprehensive social health insurance scheme.

The sophisticated health management information system (HMIS), which was supposed to retrofit the project monitoring and evaluation system faced tremendous challenges. Updating and maintenance of existing computer hardware and software infrastructure were not completed. The establishment of an alternative power source to provide operational continuity of computers was not executed because procurement and installation of solar power was not done. The HMIS lacks

a maintenance policy for the equipment, and it suffers a continuous attrition of skilled information technology staff trained by the project, which hampers the analytical capacity of the Directorate of Planning and Information. The "Service Statistics Report 2001�2004" produced by the HMIS could not provide consistent information on the health system performance.

Nevertheless, there were impressive achievements in training of health workers and designing new policy in The Gambia. The national drug policy was among the few policy development measures

to have been fully implemented as planned. Human resources development activities, drug
information and education and in-service training, IEC activities, and drug regulatory activities
were carried out. Standard treatment guidelines were reviewed and printed, and training courses
(two cycles) were organized for all subscribers. IEC campaigns for rational use of drugs were
successfully organized. Revision of drug legislation, training of medicines board inspectors and
security officers, and provision of truck and pickup for drug distribution were all executed under
the drug regulatory program. Unfortunately, the global inadequacy of drugs and medical supplies
in the central medical stores challenges the effectiveness of The Gambia's drug policy.

Through the HMIS, the Directorate of Planning and Information and the Divisional Health Team
were equipped with computers and a computer network was established for each Divisional
Health Team with a connection to Internet services. The Directorate of Planning and Information
was able to compile nationwide health statistics from the public health services for 2001�2004,
which demonstrated a substantial improvement of its capacity. The project has put in place the
basic infrastructure for HMIS.

The information, education, and communication (IEC) subcomponent produced five booklets on
various themes; broadcasted radio/TV spots in three major local languages and organized
campaigns against female genital mutilation in communities where it is largely practiced.
However, the reorganization of IEC pieces of program as a stand alone subcomponent met
resistance from the other program heads who were reluctant to release funds for the
implementation of IEC activities. Also, the program suffered from conflicting design of strategies
when a new management took over from the former head of the component. None of the
Knowledge Aptitude and Practice surveys to assess the results of the IEC subcomponent was
realized.

--Subcomponent 2: Local Initiative Fund (LIF) (US$ 0.6m).This subcomponent is rated
marginally satisfactory. Major accomplishments under the subcomponent were in the areas of

policy review of LIF, training of LIF managers and financial management staff, support to
multidisciplinary facilitation teams in the collection of data on microprojects; and community and
public sensitization on the operations and management procedures of LIF. Grant initiatives in the
Lower River Division, Central River Division, and Kaniffing Municipal Council started late, and
over 200 grants were distributed to local organizations toward the end of the project. However,
the intensification of monitoring and supervision of LIF activities in the three divisions (Kaniffing
Municipal Council, Lower River Division, and Central River Division) was not completed and a
LIF evaluation was not done.
--Subcomponent 3: Upgrading and Maintenance of Health Infrastructure (US$ 5.7m).This
subcomponent is rated marginally satisfactory. The construction of four new health facilities (not
initially planned under the project activities) and the rehabilitation of thirteen health facilities were
completed at the end of the project, but none of the new health centers was equipped and staffed.
It is unlikely that the required staff will be available in the short term given the persistent brain
drain of nurses from The Gambia.

The delegated contract with the U.K. organization Riders for Health did provide regular
maintenance services and improved timely referral of patients and availability of transportation for
supervision of health services; however, implementation was not fully successful because The
Gambia DoSH stakeholders perceived the contracting process as World Bank driven and the cost
of the contract to far exceed the benefits. Riders for Health was to develop its structure in The
Gambia through the contract, but the DoSH did not pay the cost-per-kilometer regularly; thus,
Riders for Health could not continue to deliver on its promises in a timely manner after a period of
two years. The Bank requested a technical audit of the contract, and that audit concluded that the
performance of Riders for Health was not at the standard level. Three mobile blood bank units for
GAMBLOOD (Gambia Association of Blood Donors) were completed; supervision vehicles for
GAMBLOOD were procured. As a result, GAMBLOOD tripled the stock of blood available in
the main hospitals. GAMBLOOD nevertheless raised concerns because it has lacked the resources
needed to maintain the volume of activities since the end of project.
--Subcomponent 4: Project Management (US$ 1.4m).This subcomponent is rated marginally
satisfactory. After a period of staff instability the Project Implementation Unit (PIU) was staffed

with the adequate personnel. Over time, project management significantly improved despite initial
difficulties. The PIU's improved performance was demonstrated by enhancement in disbursement.
Disbursement increased tremendously, about 85 percent, after the March 2002 midterm review.
This was said to have been facilitated by the Bank's agreeing to let the PIU obtain approval from
the Dakar, Senegal, office instead of Washington. The PIU coordinated both the World Bank and
the African Development Bank programs. With enhanced disbursement, the PIU effectively
coordinated project activities and carried out its main activities, including but not limited to
procurement of all project goods and pharmaceuticals, financial management, and coordination of
training programs. On the other hand, the PUI failed to consistently monitor, evaluate, and
document progress toward achieving the objectives of the project. All quantitative surveys, except
to the one on the nutrition component, were not done. Project achievements reports were to a
large extent descriptive rather than analytical.

4.3 Net Present Value/Economic rate of return:
Not applicable

4.4 Financial rate of return:
Not applicable

4.5 Institutional development impact:
The institutional development impact of the PHPNP in The Gambia is rated modest, because none
of the many institutional development initiatives undertaken by the project to strengthen the
Ministry of Health yielded the expected results. Two major initiatives in particular--the health
management information system (HMIS) and the continued development of GAMBLOOD--
might not be sustained. Still, the country does now have institutional structures - outside the
Ministry of Health - for effective implementation of nutrition programs. It has created a National
Nutrition Agency (NaNA) as semi-autonomous entity, which ensures successful implementation,
monitoring, and supervision of all nutrition programs in the country. NaNA received guidance
from a National Nutrition Policy Council. NaNA has obtained legal recognition of its status,
enhancing its operational leverage, and has spearheaded the development and adoption of a
national nutrition policy in The Gambia, which has become a regulatory framework for nutrition

programs. NaNA has retrofitted nutrition in other PHPNP components, such as integrated
management of childhood illness (IMCI), maternal and child health, and in nursing training
programs. In addition, NaNA has developed strong links with The Gambia's Food and Nutrition
Agency and UNICEF.

The PHPNP has contributed to the creation of the National AIDS Commission and the National
AIDS Secretariat. The National AIDS Commission has oversight responsibility of operations of
the National AIDS Secretariat, which implements all AIDS activities in The Gambia.

5. Major Factors Affecting Implementation and Outcome

5.1 Factors outside the control of government or implementing agency:
The PHPNP was launched as a major health operation in The Gambia in the period following the
coup d'etat of 1994. Under this political circumstance, the working climate was not conducive for
civil servants to take major initiatives in program development. This situation may have
contributed to the slow implementation progress of PHPNP.

In addition, the prevailing economic realities in The Gambia, coupled with rapid escalation of
prices as a result of foreign exchange increases during the project period, significantly influenced
the project's outcomes. The maintenance contract between the Department of State for Health
(DoSH) and Riders for Health, for example, was ratified under the unfavorable exchange rate of
The Gambian dalasi to the U.S. dollar. Furthermore, the substantial depreciation of the dalasi
adversely affected the upgrading and maintenance of health infrastructure subcomponent of the
project, because most spare parts were imported. The impact of these economic factors on the
procurement of goods, civil works, and maintenance was substantial. The delays in civil works
were principally caused by slow performance of the contractors to GAMWORKS.

5.2 Factors generally subject to government control:
The GoTG supported a participatory workshop conducted for discussion by both Gambians and

the World Bank team. The workshop gave opportunity for the Gambians to have candid
discussions with the Bank team, and also to come out with a package of project activities for

implementation. Following the midterm review, the GoTG took action to address slow
disbursement problems, which were identified by the joint review team. It promptly prepared a
new action plan, which improved procurement procedures. The GoTG hired a short-term
procurement expert to reinforce the Project Implementation Unit (PIU).

Despite these efforts, government shake-ups and voluntary retirement of top officials at the time
had substantial effects at each stage of the project. Key sector personnel were replaced and
retired, and a new Health Minister was named after the January 1997 elections. The effects of
these simultaneous changes made moving forward rapidly with project preparation more difficult,
and resulted in a host of implementation delays. During the lifetime of the project, there were four
different Ministers of State and many more Permanent Secretaries who were successively
appointed for the Health Department. Furthermore, the President's office was said to have
engaged in-line ministries' decisions without prior notice--a hospital complex in Farafani, for
example, was decided upon and designed without the involvement of the DoSH. All these factors
worked to the detriment of the continued implementation of the The Gambia's health sector
strategy and the implementation of the PHPNP.

5.3 Factors generally subject to implementing agency control:
The impact of factors subject to the control of the implementing agency has been substantial.
Subsequent to the PHPNP's effectiveness, disbursements were slower than anticipated. The
disbursement rate as of October 2002 (four years after effectiveness of the project) was only 37
percent. The PIU has been understaffed since the departure of the project manager and financial
controller and the financial controller left to take higher position with the Islamic Development
Bank. Other personnel changes that affected the PIU took place. After the 2002 midterm review,
the PHPNP's project management and the pace of implementation of virtually all of the
components and subcomponents of the project improved.

From the 2002 midterm review to the end of the PHPNP, health services in The Gambia
continued to suffer a high turnover of staff at different levels. Although the personnel contracted
by the project showed great commitment to their work program, many directors--civil servants
and in charge of implementation of different components of the project--were less motivated to
perform.

5.4 Costs and financing:
In the project appraisal document, the estimated total project cost for the PHPNP, including
contingencies, was US$19.9 million. The total baseline project cost was estimated at US$17.6
million. The total actual project cost over the entire life of the PHPNP is approximately US$20.0
million. IDA credit allocation at the time of project appraisal amounted to SDR 13.4 million,
which was US$18.6 million equivalent. Total credit amount disbursed at the end of project
amounted to SDR 13.3 million (US$19.2 million), representing about (99 percent) of the initial
credit amount. An amount of US$144,000 was reported undisbursed.

An undisbursed amount of US$1,200 out of a US$250,000 Japanese Grant prov

http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2006/06/07/000090341_20060607104525/Rendered/INDEX/35610.txt