Summative Evaluation: Building Resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019
January 2020
# Table of Contents

Acknowledgements ........................................................................................................................................ 7

Executive summary ......................................................................................................................................... 8

1  Introduction, background and context ................................................................................................. 16
   1.1  Background and context ............................................................................................................................ 16
   1.2  Evaluation purpose .................................................................................................................................... 18
   1.3  Evaluation objectives ................................................................................................................................. 18
   1.4  Evaluation scope ........................................................................................................................................ 19
   1.5  Evaluation criteria ...................................................................................................................................... 20
   1.6  Evaluation questions .................................................................................................................................. 21

2  Evaluation Object ................................................................................................................................. 22
   2.1  BReST Project objectives ........................................................................................................................... 22
   2.2  BReST project design .................................................................................................................................. 23
   2.3  Project Management and Coordination Structures and other stakeholders ............................................ 26
   2.4  Theory of Change ....................................................................................................................................... 28

3  Evaluation Methodology ...................................................................................................................... 32
   3.1  Qualitative methods .................................................................................................................................. 32
   3.1.1  Documentary review ................................................................................................................................. 32
   3.1.2  Key informant interviews .......................................................................................................................... 33
   3.1.3  Focus group discussions ............................................................................................................................ 34
   3.1.4  Field Observations ..................................................................................................................................... 35
   3.1.5  Qualitative data analysis ............................................................................................................................ 36
   3.2  Quantitative methods ................................................................................................................................ 36
   3.3  Limitations and challenges of the qualitative and quantitative methods .................................................. 37
   3.4  Ethical Considerations ............................................................................................................................... 39

4  Evaluation findings and Preliminary Findings (by criterion)................................................................... 40
   4.1  Relevance ................................................................................................................................................... 40
   4.2  Impact ........................................................................................................................................................ 48
   4.3  Effectiveness .............................................................................................................................................. 64
   4.4  Efficiency ................................................................................................................................................... 74
   4.5  Sustainability ............................................................................................................................................. 83
List of figures

Figure 1. Map of the Gambia and intervention regions: North Bank, Central River, Upper River ........... 20
Figure 2. Project management and coordination structures ........................................................................ 28
Figure 3. BReST Theory of change .............................................................................................................. 30
Figure 4 Improvement in child nutritional status between 2016 and 2019 by region .......................... 49
Figure 5 Improvement in child nutritional status between 2016 and 2019 in NBR East, by HF ............ 50
Figure 6 Improvement in child nutritional status between 2016 and 2019 in URR, by HF .................... 50
Figure 7 Improvement in child nutritional status between 2016 and 2019 in NBR West, by HF .......... 50
Figure 8 Improvement in child nutritional status between 2016 and 2019 in CRR, by HF .................. 50
Figure 9 Evolution of global and severe acute malnutrition among BReST beneficiaries .................. 51
Figure 10. Proportion of exclusive breastfeeding .......................................................................................... 53
Figure 11: Proportion of children with a minimum dietary diversity, minimum meal frequency, and
minimum acceptable diet.......................................................................................................................... 56
Figure 12. Access to clean drinking water during dry and rainy seasons .............................................. 56
Figure 13. Proportion of women using adequate water treatment techniques when needed ................ 56
Figure 14. Proportion of women washing their hands at critical moments ............................................... 57
Figure 15. Proportion of women who delivered in a health facility ......................................................... 57
Figure 16. Institutional delivery increase between Q1-Q2 of 2016 and Q1-Q2 of 2019 in BReST HFs and
Non-BReST HFs in NBR, CRR and URR .................................................................................................. 58
Figure 17. Proportion of women with savings the past 24 months ......................................................... 60
Figure 18. Proportion of women who bought livestock during the last 24 months ............................... 60
Figure 19. Women’s participation in IGA .................................................................................................... 61
Figure 20. BReST women participation in IGA, by sector ........................................................................... 61
Figure 21: Ownership of Birth Certificate among BReST Beneficiary Children .................................. 62
Figure 22. Channels for counselling sessions ............................................................................................. 71
Figure 23. Absenteism during BReST implementation .............................................................................. 80
Figure 24. Conceptual framework for the equity-based approach .......................................................... 137
Figure 25. Main stages of an individual’s life-cycle ................................................................................... 138

List of tables

Table 1: Expected evaluation users and uses ............................................................................................. 18
Table 2. Key Informants Interviews ............................................................................................................ 33
Table 3. Focus group discussions during the evaluation ........................................................................... 35
Table 4. Sampling frame ............................................................................................................................. 37
Table 5. Exclusive breastfeeding rates amongst BReST beneficiaries vs the entire population ............. 54
Table 6. Minimum dietary diversity, BReST beneficiaries vs entire population ....................................... 54
Table 7. Rates of minimum dietary diversity, minimum meal frequency and minimum acceptable diet
when the mother invested in productive assets ....................................................................................... 60
Table 8. Achievement of project indicator ................................................................................................ 66
Table 9. Proportion of women who received counselling ......................................................................... 70
Table 10. Financial expenditure based on BReST Interim Progress Report for the period 1st August 2017 – 31st July 2018............................................................................................................................................... 76
Table 11. GAM prevalence and estimated sample size, by region ..................................................................... 184
Table 12. Sampling frame........................................................................................................................................ 184
Table 13. MUAC measurement per months: missing values, number of observations, and minimum and maximum values......................................................................................................................................... 189
Table 14. BReST regions and corresponding LGAs in national surveys............................................................... 190

List of illustrations

Illustration 1. Immunization schedule hanging at the Health Facility among BReST sensitization materials (@UNICEF Gambia / 2019)............................................................................................................................... 40
Illustration 2. Shared use of SCOPE software (by WFP and BReST Monitoring staff) for recording beneficiary data............................................................................................................................................ 44
Illustration 3. A Public Health Officer in NBR explains mother and child health trends in a Health Facility since the inception of the BReST project (@UNICEF Gambia / 2019) ........................................................................................................................................ 48
Illustration 4. Behavioural Change flipchart used by BReST during the Health counselling sessions at the health facility (@UNICEF Gambia / 2019).............................................................................................................................................. 64
Illustration 5. Example of Behavioural change flipchart used by BReST during health counselling sessions ...................................................................................................................................................................... 69
Illustration 6. BReST Beneficiaries’ lists used to check identities and validate payments, Demban Kunda Koto, Upper River Region (@UNICEF Gambia /2019) ................................................................................................................................................. 74
Illustration 7. WhatsApp Network created by Social Workers and NaNA staff to share information on the BReST project and other social and health related matters (@UNICEF Gambia/2019) .................................................................................................................. 83
Illustration 8. Tricycle ambulance purchased with community funds, Basse, Upper River Region........ 85
Illustration 9. Mother and child benefitting from the cash transfer program....................................................... 87
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>BReST</td>
<td>Building Resilience through Social Transfers for nutrition security in the Gambia</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination Against Women</td>
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<tr>
<td>CHN</td>
<td>Community Health Nurse</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CRR</td>
<td>Central River Region</td>
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<tr>
<td>CT-card</td>
<td>Cash Transfer-card</td>
</tr>
<tr>
<td>DCD</td>
<td>Department of Community Development</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DSW</td>
<td>Department of Social Welfare</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>GAM</td>
<td>Global Acute Malnutrition</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GFPA</td>
<td>Gambia Family Planning Association</td>
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<td>GMD</td>
<td>Gambian Dalasi</td>
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<td>HF</td>
<td>health facilities catchment areas</td>
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<td>IGA</td>
<td>Income Generating Activities</td>
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<td>IYCF</td>
<td>Infant and young child feeding</td>
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<td>KII</td>
<td>Key Informant Interview</td>
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<td>LGA</td>
<td>Local Government Administrations</td>
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<td>MCNHRP</td>
<td>Maternal and Child Nutrition and Health Result Project</td>
</tr>
<tr>
<td>NDP</td>
<td>National Development Policy</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<td>MOA</td>
<td>Ministry of Agriculture</td>
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<td>MOFEA</td>
<td>Ministry of Finance and Economics Affairs</td>
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<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<td>NSPP</td>
<td>National Social Protection Policy</td>
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<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
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<td>NACCUG</td>
<td>National Association of Cooperative Credit Unions of The Gambia</td>
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<td>NaNA</td>
<td>National Nutrition Agency</td>
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<td>NBR</td>
<td>North Bank Region</td>
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<tr>
<td>OIC</td>
<td>Officers in Charge</td>
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<td>PMT</td>
<td>Project Management Team</td>
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<td>PNC</td>
<td>Prenatal Consultation</td>
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<td>PSC</td>
<td>Project Steering Committee</td>
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<td>PSP</td>
<td>Payment Service Provider</td>
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<td>QR-code</td>
<td>Quick Response code</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>ROM</td>
<td>Results Oriented Monitoring</td>
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<td>SAM</td>
<td>Severe Acute Malnutrition</td>
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<td>SMART</td>
<td>Standardized Monitoring and Assessment of Relief Transition</td>
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<td>SSA</td>
<td>Sub-Saharan Africa</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>URR</td>
<td>Upper River Region</td>
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<tr>
<td>VDC</td>
<td>Village Development Group</td>
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<tr>
<td>VSD</td>
<td>Village Support Group</td>
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<tr>
<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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The report is informed by the opinions and suggestions of a variety of stakeholders; however, the evaluators take full responsibility for its contents.

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End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

Executive summary

UNICEF Gambia commissioned SPRI to conduct a summative evaluation of the BReST project. The project was implemented in three regions in the Gambia, the North River Region (NRR), the Central River Region (CRR) and the Upper River Region (URR), jointly by the National Nutrition Agency (NaNA), and the Ministry of Health and Social Welfare (MoHSW), supported by the UNICEF Gambia country office. The BReST project combined unconditional cash transfer with a strong nutrition education component. It applied two interrelated pathways, i.e. resilience building through cash transfers for food and nutrition security and improved nutritional and caring practices through nutrition education and hygiene promotion targeting mothers. With the two pathways, the project aimed to improve household income to access sufficient and diversified food, and at the same time improve knowledge and skills for better nutrition practices of lactating mothers and their babies.

1. Evaluation purpose, objectives, scope

The summative evaluation had two purposes: accountability to both donors and expected beneficiaries as well as organizational learning. Lessons learnt and recommendations will be used for future programmes and policy discussion around social protection in the Gambia. The evaluation objectives were to determine the project’s relevance, effectiveness, efficiency, sustainability, impact, and the extent to which it had integrated equity, gender and human rights considerations. Evidence-informed findings, lessons learnt, and specific actionable recommendations were provided to contribute to the planning and strategic discussion of a successor project in social protection sector as per the Gambia National Social Protection Policy 2015-2020 as well as UNICEF strategic document. The evaluation will also be used for policy advocacy and communication through the identification and dissemination of lessons learnt and good practices.

All project components were evaluated, namely the cash transfers, advocacy and Infant and Young Child Feeding Practices education components. The evaluation covered the entire project period (August 2016 to October 2019), and all the three BReST intervention regions.

2. Evaluation methodology

The evaluation framework was based on six criteria: the five OECD/DAC evaluation criteria (Relevance, Effectiveness, Efficiency, Impact and Sustainability) and an additional criterion on gender, equity and human rights. Specific questions were developed in the ToRs and further adjusted during the inception phase for each criterion. The evaluation methodology was anchored in a cross-cutting approach encompassing: (i) the equity-based and human-rights approach, (ii) the life cycle approach, (iii) the economic approach, and (iv) the participatory approach. The evaluation relied on the use of mixed-methods (qualitative and quantitative) to address each one of the evaluation questions. The mixed approach was particularly effective in that it made it possible for the evaluation team to reach measurable
and relevant conclusions based on a triangulated interpretation of the results. In addition to primary data collection and analysis, the evaluation team made use of secondary data (Project administrative data, MICS 2018, SMART 2015, GMNS 2018) to inform findings and analysis.

For the primary data collection, the qualitative data collection methods included documentary review, key informant interviews (29 KII), focus group discussions (40 FGD) and field observations. As for quantitative methods, a quasi-experimental design was used to assess the effects and impact of the project; 326 questionnaires were administered to women with children less than 3 years old, divided equally into control and treatment groups. All the ten-priority health facility catchment areas in the 3 BReST regions were visited for both qualitative and quantitative data collection.

3. Evaluation findings (by criterion)

Relevance. The evaluation team analyzed the relevance of BReST in terms of its adequacy with the main national public strategies and policies along with synergies with other programs, understanding of cultural norms and gender dynamics. The evaluation concluded that BReST fits perfectly into the Gambian institutional framework, with a view to gradually extending the social protection schemes and tackling malnutrition. Targeting about 6,000 mothers of newborn babies, in 10 selected priority health areas in NBR, CRR and URR, the project provides a comprehensive response to nutrition and health issues with a holistic approach combined with a monetary benefit and close support to the beneficiaries and their children. The evaluators found strong synergies between BReST and other interventions, mainly the World Bank funded MCHNRP project. BReST stands as continuation of the latter including as beneficiaries the mothers who were previously supported by MCHNRP, thus enabling an adequate support to mothers and their children during the first 1000 days of life.

Impact. The project displays positive effects on beneficiary children’s nutrition status, particularly during the lifetime of the project. When comparing the rates of acute malnutrition (SAM) and global acute malnutrition (GAM) in BReST catchment areas and non-BReST catchment areas, the project’s effect was particularly apparent in NBR-East and to a lesser extent in URR, while NBR-West and CRR did not show notable effects. However, these effects seem to fade as soon as the cash transfer stopped: although minimum dietary diversity was found to be significantly higher among BReST beneficiaries during the project, these gains were not observed post-project. Despite improved knowledge gained from the project, some positive practices have not been maintained beyond the project period due to the absence of monetary support.

Improved right-holders knowledge translates into higher rates of exclusive breastfeeding, deliveries assisted by skilled personnel and improved hand washing practices, but not into adequate water treatment techniques. Interestingly, evidence shows the BReST project contributed to reducing gender differences in diet diversity and meal frequency. The evaluation found a significant difference between girls and boys in
terms of minimum dietary diversity and minimum acceptable diet in the control group, but there is no difference among BReST beneficiaries.

The BReST project shows positive effects on household’s economic resilience by improving household productive capacity or savings, as the majority of women invested or saved some of the cash transfer they received. Additionally, increased birth certificate ownership is seen as an important unintended effect of the programme. Though not part of the initial objectives, birth registration service was included in the BReST project and resulted in a significantly higher birth certificate ownership among beneficiary children (on average 80.1%), compared to only 47% in the population of children under 5 in the Gambia.

Effectiveness. The BReST project has reached its target of 10 Health Facility catchment areas and exceeded its target of 5,500 women with a total of 6,176 women registered and between 5,556 and 5,898 women received the cash transfers each month. Increasing the effectiveness by covering additional beneficiaries was possible as the project managed to increase the efficiency by optimising the use of funds. The project is considered effective in building capacities of government partners in implementing social transfers and collating evidence on the importance of such project. The BReST project was for the most part implemented by national institutions including NaNA, Department of Social Welfare (DSW) and the Ministry of Health (MoH), supported by UNICEF. Project staff from the aforementioned agencies are knowledgeable about the project and their respective responsibilities and implementation at national, regional and health facility level ran smoothly. Trainings were provided to project staff at different levels and the contents were satisfactory. However, these trainings were only conducted once during the inception phase and did not include staff of payment institution. The nutrition education, conducted face-to-face on the payment site, was in general considered effective by both institutional stakeholders and beneficiaries. The verbal communication was easily understandable and accompanied with descriptive illustrations. A weakness of the nutrition education component is that in some health centres, due to the large number of beneficiaries, beneficiaries had to queue for a long time without sufficient seating facility.

Efficiency. The cash transfer of GMD 600 per month, or roughly 25% of monthly per capita expenditure, is meaningful in helping the households improve care and nutrition of the children. However, in places where beneficiaries are spread out in a large catchment area the benefit can be effectively reduced by 1/4 due to high transport costs associated with collecting the payment. For future projects, stakeholders suggested to take into account the distance to payment sites when calculating benefits, or to divide the catchment area into several points to ensure reasonable distance for all beneficiaries.

The composition of the project expenditures, including nearly 50% of the budget disbursed directly to beneficiaries as cash transfer, shows a cost-efficient operation. Although electronic money transfer options were considered as an alternative, the manual cash payment system was the only viable option given the lack of infrastructure and low literacy among beneficiaries. The payment system put in place for BReST proved very efficient throughout the implementation of the project. The combination of human resources from UNICEF, NaNA, the National Association of Cooperative Credit Unions of The Gambia
(NACCUG), DSW and Health Facilities provided the project with the necessary set of expertise to run the project efficiently. The role of social workers was crucial, but their number was relatively small, and the equipment provided to them was limited. Unfortunately, this limitation is not specific to the BReST project, Gambia has a low number of social workers although their roles in various social programmes are very important.

**Sustainability.** The evaluators examined the project's sustainability conditions, based on an analysis of existing capacities and capacities built during the implementation, and sustainability of achievements. The data analysis highlights the “legacy” of BReST in terms of capabilities. The latter will undoubtedly be useful in the context of a possible extension of BReST or in the implementation of broader social protection interventions. Likewise, the evaluation team found a good level of ownership and achievements resulting from the project as proved, for example, by the application of good health practices promoted through the education sessions. Certain economic factors which weigh on local populations - such as transport to reach the health facility - can constitute risk factors in the medium and long term and perpetuate BReST achievements.

**Gender and Human Rights.** BReST focus on women and their babies is a first step towards adoption of a gender-sensitive approach. The design of BReST offers a holistic approach focused on the needs of the child during the first years of life and their mothers while supporting the role of mothers with specific counselling and monetary benefit. However, the evaluation team finds that the project does not fully involve men in the mechanisms of action, thus neglecting the role they could play in promoting good care practices within the household.

The evaluation team concludes that BReST's mechanisms proved effective in addressing barriers that prevent girls' and women's access to the services as shown by improvement in mothers and children’s health and nutrition status and continuous use of health services. The combination of the incentives (service utilization, cash transfers and nutritional and health advice) acts against access barriers and contributes to economic empowerment of women. This report also highlights a good dynamic of gender relations inside the household. Among unexpected results, BReST created positive dynamics within the family, enabling spaces for dialogue between the beneficiaries and their spouses regarding the use of the cash transfer.

**4. Key conclusions (by criterion)**

The BReST project has proved to be relevant and efficient in providing a comprehensive response to nutrition and health issues. Below are the key evaluation conclusions.
### Evaluation criteria | Key conclusions
--- | ---
**Relevance** | • The evaluation concluded that BReST fits perfectly into the Gambian institutional framework, with a view to gradually extending the social protection schemes and tackling malnutrition. The project provides a comprehensive response to nutrition and health issues with a holistic approach combined with a monetary benefit and close support to the beneficiaries and their children.  
• The BReST project fits well the complementary project of other organization like WFP. The project did not start with a throughout analysis of social norms and habits. From the perspective of designing relevant interventions for pregnant mothers and very young children, the BReST project can provide valuable insights for other countries or for further development of similar interventions in The Gambia.

**Impact** | • The project displayed positive effect on beneficiary children’s nutrition status, particularly during the lifetime of the project. However, some of these positive effects seem to fade as soon as the cash transfer stopped.  
• Improved knowledge among beneficiaries translated to higher rates of exclusive breastfeeding, skilled delivery, hand washing practices, and birth certificate ownership among beneficiary children.  
• The BReST project showed positive effects on household’s economic resilience by improving household productive capacity and savings.

**Effectiveness** | • The BReST project has reached its target of 10 Health Facility catchment areas and exceeded its target of 5,500 women with a total of 6,176 women registered and between 5,556 and 5,898 women received the cash transfers each month.  
• The project is considered effective in building capacities of government partners in implementing social transfers and collating evidence on the importance of such project.  
• The BReST has been effective in changing the behaviour around breastfeeding, birth registration and diets. It is troubling that the behavioural change in terms of food diversity and meal frequency did not result in long term changes due to the fact some families proved to be too poor to sustain the behaviour after the cash transfer was stopped.

**Efficiency** | • Overall, the cash transfer of GMD 600 per month, or roughly 25% of monthly per capita expenditure, is meaningful in helping the households improve care and nutrition of the children.  
• The composition of the project expenditures shows a cost-efficient operation.
### Key Lessons learnt

Four lessons learnt came out of the evaluation. They can be used to inform future social protection projects/programmes both in Gambia and in the rest of the region, provided that designed programmes are similar in terms of targeted beneficiaries and geographical scope.

**Lesson 1.** Integration of services toward the child at the same place as the cash disbursement has the potential to increase the coverage of these services, and hence improve the fulfilment of the rights of the child.

**Lesson 2.** Regular and predictable cash transfers, in addition to counselling in IYCF, are powerful in improving feeding practices and health and nutrition.

**Lesson 3.** An adequate baseline and evaluation planned from the onset of the project allow making more precise and stronger conclusions about the impact of the project on its beneficiaries.
Lesson 4. Analysing the roles and responsibilities of both men and women in projects seeking improved health and nutrition status of women and children during the design stage is key, since appropriate targeting of the sensitization activities has the potential to increase the impact of the behavioural change communication and bring primary care-givers (men and women) to invest more in better child feeding practices during and at the end of the project.

Lesson 5. The arrangements both with Implementing partners and Civil Society proved very efficient and demonstrates that the model designed for BReST can serve as a reference for other cash transfer programs in the region.

6. Recommendations

Strategic and operational recommendations (the corresponding recipients are indicated inside the squared brackets below) were developed by the evaluation team based on the key conclusions as well as the exchanged held with the different evaluation stakeholders and envisaged users during the validation workshop that took place on January 23, 2020.

Strategic recommendations

- Capitalize on existing knowledge at the central and regional level for the ongoing design of the Social protection strategy and policies through (i) the strengthening of the Social Protection Secretariat capacities for coordination and knowledge capitalization/sharing and strengthening of its relations with the newly created Ministry of Women Affairs, Children and Social Welfare; (ii) the continuous trainings on specific social protection topics with actors involved in implementation of social protection projects at national and regional levels; (iii) the presentation of the evaluation at the Social Protection Forum to advocate for more investment in such projects [UNICEF Country Office in The Gambia, National Secretariat for Social Protection, Ministry of Women Affairs, Children and Social Welfare];
- Target social cash transfers to the household and community instead of the individual. It is necessary to fully include the role of men in the mechanics of projects targeting women/children [National Secretariat for Social Protection];
- Pursue the efforts in reducing Malnutrition and improving Resilience under a sustainable national Social protection strategy, with a focus on institutional dialogue and capacity building [National Secretariat for Social Protection, Ministry of Women Affairs, Children and Social Welfare, Ministry of Health];
- Build on existing capacity, increase the number of social workers and value their image [Ministry of Women Affairs, Children and Social Welfare];
- Increase the involvement of Regional governments and Department of Community Development in project implementation for better coordination and sustainability [National Secretariat for...
Social Protection, Regional governments, Ministry of Land and Religious Affairs/ Department of Community Development.

Operational recommendations

- Reduce the costs for beneficiaries in obtaining benefits by bringing payment sites closer to them [National Secretariat for Social Protection];
- Ensure that social protection training programs are provided to all project staff and organized on a continuous basis, with priority given to new staff [UNICEF Country Office in The Gambia, National Secretariat for Social Protection];
- Establish an adequate baseline at the launch of a project to adequately monitor and evaluate the project [UNICEF Country Office in The Gambia, National Secretariat for Social Protection];
- Reinforce the monitoring system with proper monitoring tools, which will collect in a consistent and standardized way relevant data in all the project sites [UNICEF Country Office in The Gambia; National Secretariat for Social Protection, Ministry of Women Affairs, Children and Social Welfare, Ministry of Health].
1 Introduction, background and context

1.1 Background and context

Despite the improvements attained over the last decade (infant mortality declined from 81 to 34 deaths per 1000 live births and under five mortality declined from 109 to 54 deaths per 1000 live births according to MICS 2010 and DHS 2013), the overall social conditions in Gambia are still very poor. The Gambia remains one of the poorest countries in sub-Saharan Africa, with a GDP per capita of roughly US$ 23171 and almost half (48.6%) of the population estimated to be poor according to the World Development Indicators (World Bank, 2019). In most sectors (health, education, employment, etc.), the situation has even worsened in the last decades. The country’s human development index was ranked in 2018 as one of the world’s lowest, 174 out of 189 (UNDP, 2018). In addition, significant disparities prevail in terms of poverty between urban and rural areas. Indeed, poverty remains a rural phenomenon: between 2010 and 2015, the poverty rate decreased in urban areas and increased in rural areas. Income poverty is particularly high among households headed by subsistence farmers and low-skilled workers, but also among children. According to the Integrated Household Survey 2010 (IHS 2010), poverty rates were 55.6% and 55.8% among children aged 0-5 years and 6 -14 years respectively.

In a context of high population growth, agricultural production is limited, and the Gambia relies heavily on imports of staple foods. Low agricultural production, recurring droughts and poverty contribute to the food insecurity and malnutrition of the population, and in particular children. According to MICS 2018, stunting prevalence among under 5 is 19%; 13.9% when it comes to underweight, and 6.2% for wasting. Only 13.5% of children aged 6 to 23 months who are breastfed have a minimum acceptable diet. This percentage goes down to 7.2% when the child is not breastfed.

As stipulated in the Convention on the Rights of the Child (CRC) signed and ratified by The Gambia in 1990, every child has a fundamental right to survival which is essential to preserve from the first days of life. As such, the elimination of malnutrition must be an absolute priority since it contributes directly to infant mortality, gender equality and poverty reduction (art.24). Children who are chronically undernourished before their second year of life are likely to have diminished cognitive and physical development for the rest of their lives.

---

1 2018, GDP per capita, PPP (constant 2011 international $)
Reducing malnutrition is a core objective of the National Development Plan 2018-2021 (NDP), in which a special attention is given to mothers and children. The BReST project is specifically mentioned in the NDP as a key initiative in social protection to address vulnerabilities, including strengthening child protection (Republic of the Gambia, 2018). The BReST project, funded by the European Union, is expected to contribute to maternal and child health and nutrition by improving the status of lactating mothers and children under the age of 2 years old. More specifically, the project aims at reducing acute malnutrition levels by 10% and improving the nutritional practices of target populations. Because of its objective to help reducing the vulnerability of children and mothers, the BReST project is anchored in a fundamental rights approach and in line with obligations emanating from the CRC.

The BReST project is an important step towards the set-up of a broader framework, in particular that of the National Social Protection Policy (NSPP, 2015-2025) aimed at achieving better integration between social protection programmes.
1.2 Evaluation purpose

The evaluation had two purposes: accountability to both donors and expected beneficiaries as well as organizational learning. In addition to strengthening the UNICEF Country programme in line with its Strategic Plan and SDGs outcomes, the results of the evaluation should provide strategic direction to the UNICEF CO and other stakeholders (the National Nutrition Agency, the Ministry of Women, Children and Social Welfare, European Union, beneficiaries, the World Bank, etc.) for the design and implementation of future social protection programmes, and support the efforts to attain improved nutritional and social protection outcomes, and enhance the effectiveness of the social protection advocacy work. Table 1 presents the expected evaluation users and uses.

<table>
<thead>
<tr>
<th>Evaluation users</th>
<th>Evaluation uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF</td>
<td>To inform and adjust where required as their Country Programme Strategy for the period 2017-2020 by better understanding the contributions of the BReST project</td>
</tr>
<tr>
<td>Development partners in social protection</td>
<td>The UNICEF Social Protection Section, in collaboration with all other partners involved in the implementation of the United Nations Development Assistance Framework (UNDAF), will benefit to identify strategic/implementation changes to their strategy. Development partners working in social protection will benefit to obtain lessons learnt and recommendation from the evaluation for project design and strategic direction in national social protection strategy and programme</td>
</tr>
<tr>
<td>(World Bank, UN partners etc)</td>
<td></td>
</tr>
<tr>
<td>Donors</td>
<td>Will better articulate the outcome and impact in their intervention and inform future interventions</td>
</tr>
<tr>
<td>Government (including NaNA)</td>
<td>Will better define the term of collaboration with UNICEF with respect to the attainment of the relevant goals set in the national development plan</td>
</tr>
<tr>
<td>NGOs/CSOs</td>
<td>Mainstream (into their day-to-day practices) the good practices identified during the evaluation and address the weaknesses emerged during the analysis</td>
</tr>
</tbody>
</table>

1.3 Evaluation objectives

The objectives of the evaluation were to:

- Determine the relevance, effectiveness, efficiency, sustainability and impact of the BReST project;
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

- Assess the extent to which the project has integrated equity, gender and human rights principles in its design, implementation and monitoring and succeeds in reaching the most vulnerable groups (extremely poor, hard to reach communities, marginalised groups and other disadvantaged groups);
- Identify unmet priorities of the BReST project as well as unexpected outcomes (positive and negative);
- Provide evidence-informed findings, lessons learnt and specific actionable recommendations to contribute to the planning and strategic discussion of a successor project in social protection sector as per the Gambia National Social Protection Policy 2015-2020 as well as UNICEF strategic document;
- Identify good practices and provide evaluation brief(s) for policy advocacy and communication purpose based on the evaluation report.

1.4 Evaluation scope

Thematic scope:

The project activities to be evaluated are the cash transfer, advocacy and Infant and Young Child Feeding Practices education components.

Chronological scope:

The evaluation covers the implementation of the entire project period (August 2016 to October 2019). While the project field activities phased out in October 2019, the project will officially end February 2020 to enable this evaluation and the last required asset transfers to be completed.

Geographical scope:

The evaluation covers all the three intervention regions of BReST with interaction with national provincial, district and community level stakeholders. All intervention areas were visited by the evaluation team to ascertain the contribution of the project and to solicit beneficiary perspectives. Figure 1 below presents a map of the Gambia, with the 3 intervention regions: North Bank Region, Central River Region and Upper River Region.
1.5 Evaluation criteria

Following the methodological guidelines set out in the Terms of Reference and in order to attain the evaluation envisaged purposes and objectives, the evaluation team let six criteria guide their work: the five OECD/DAC evaluation criteria (Relevance, Effectiveness, Efficiency, Impact and Sustainability) and an additional criterion on gender, equity and human rights. For each one of the six criteria, a brief definition is provided below:

- **Relevance** refers to the extent to which the project is suited to the priorities and policies of the target group, recipient and donor.
- **Effectiveness** is a measure of the extent to which the project attains its objectives.
- **Efficiency** measures the outputs (qualitative and quantitative) in relation to the inputs.
- **Impact** refers to the positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended.
- **Sustainability** is concerned with measuring whether the benefits of the project are likely to continue after donor funding has been withdrawn (Chianca, 2008).
- **Gender, equity and human rights** is concerned with the extent to which equal rights of women and girls, basic fairness of the processes and outcomes of decision making, and basic human rights of people are promoted and respected.
1.6 Evaluation questions

The 21 evaluation questions, grouped by criterion, are listed below. The complete evaluation matrix, including the sources that provided the data necessary to answer each question, can be found in Annex 4. During the evaluation process, upon agreement with UNICEF, the evaluation questions were modified to better capture the development of the project and to avoid redundancy of information.

**Relevance:**

1. To what extent are the BReST Project's interventions aligned with the Gambia Government identified priorities (i.e. National Social Protection Policy & National Development Plan)?

2. To what extent does the BReST project respond to the identified needs among its expected beneficiaries?

3. How complementary are the UNICEF BReST interventions with those implemented by the World Bank, government and other partners to reach the most vulnerable? What are the areas where complementarity was lower than expected?

4. To what extent were the Project’s expected results clearly stated and measurable through identifiable indicators and disaggregated by sex and age?

5. To what degree were the project interventions based on a thorough review of cultural and social norms?

**Impact:**

6. Is there any lasting change that could be identified with regards to the health and nutrition of women and children in the BReST project?

7. To what extent has the project contributed to increasing beneficiary households’ resilience to income shocks?

8. To what extent has the BReST project increased identity documents in the targeted communities?

**Effectiveness:**

9. To what extent did the BReST project achieve its expected results?

10. To what extent has the project contributed to behavioural change in nutrition and care practices in the targeted communities?

11. Were the project’s behavioural change and communication strategies appropriate to achieve the expected results?

12. What (if any) are the project unintended and unexpected results

**Efficiency:**

13. To what extent were financial resources in the BReST project adequate and used efficiently?

14. What could have been done to attain the same BReST project objectives but at a lesser cost?

15. To what extent were human resources in the BReST project adequate and used efficiently?

16. To what extent were the payment operations properly handled?
Sustainability:

17. To what extent did the project identify and build an existing national and local civil society and government capacities, structure and mechanisms to avoid dependency on UNICEF funds overtime?
18. To what extent were the project achievements sustained and for the most recent ones how will they be sustained when external support ends?
19. What has been done and what can stakeholders do more to ensure that project achievements are kept and improved further over time?

Gender, Equity and Human rights:

20. To what extent were Gender, Human Rights and Equity principles duly integrated in the design, delivery and monitoring of the project?
21. To what extent did the BReST project tackle the barriers that prevent girls' and women's access to the services that it made available in the targeted communities?

2 Evaluation Object

This section describes the object of the evaluation - the BReST-project in terms of its objectives, main components and organization of the implementation.

2.1 BReST Project objectives

The overall objective of the BReST project was to build resilience and improve the nutritional status of lactating women and children under the age of two in North Bank Region (NBR), Upper River Region (URR), and Central River Region (CRR) in the Gambia. The Indicator for the achievement of this objective was a 10% reduction in the prevalence of acute malnutrition in children under two years of age.

Two specific objectives were identified:

SO1: Improved nutritional status and caring practices for women with children under 2 by providing cash transfer and resilience building. This specific objective has four indicators: (1) a 10% increase in individual dietary diversity score, (2) an increase in the frequency of child meals, (3) an increase in the diversity of child meals, and (4) an increase of exclusive breastfeeding practice for the first six months among the mothers, reaching a total of 52% of them.

SO2: Improved implementation of related Government Policies through building capacities of government partners and civil society organisations. The indicator for this objective is that stakeholders (Government,
NGO, private sector) have increased capacity and evidence on the effectiveness of social protection using conditional cash transfers.

The expected intermediate results of the project include:

**ER1**: Income provided to mothers of children 0-24 months. The indicator is that 5,500 women are expected to receive cash transfers of 600 GMD/month for a duration of 24 months.

**ER2**: Enhanced knowledge and skills in mother, infant and young child feeding practices. It has two indicators, namely (1) number of mothers that will have been counselled for infant and young child feeding practices; and (2) number of children receiving vitamin A supplementation and deworming.

**ER3**: Increased attendance at growth monitoring sessions. The indicator here is the number of women attending a mother and infant welfare session.

**ER4**: Evidence based advocacy and capacity building activities conducted for introducing and expanding cash transfer projects. The indicators include (1) number of advocacy workshops conducted; and (2) the number of advocacy materials produced and disseminated.

In order to achieve optimum impact, the project was developed in complementarity with other relevant projects, particularly the World Bank’s Maternal and Child Nutrition and Health Result Project (MCNHRP) which provides support to health facilities, communities and pregnant women to improve community nutrition and primary maternal and child health services. The targeting and institutional frameworks of BReST were specifically made in line with those of the MCNHRP.

### 2.2 BReST project design

**Project Components: Cash Transfer and Nutrition Education**

The BReST project combined unconditional cash transfer with a strong nutrition education component. The project applied two interrelated pathways, i.e. resilience building through cash transfers for nutrition security and improved nutritional and caring practices through nutrition education for mothers. With the two pathways, the project aimed to improve household income to access sufficient and diversified food, and at the same time improve knowledge and skills for better nutrition practices of lactating mothers and their babies.

The cash transfer component provides each female beneficiary with GMD 600 (approximately 10.5 EUR) per month for a total period of 24 months. Monthly payments were made in cash by an independent payment service at the health facilities.

The nutrition education component was aimed to sensitise and educate lactating women on, among others, breast feeding, appropriate complementary feeding practices, water, sanitation and hygiene
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

(WASH) and dietary diversity. The educational component of the project was intertwined with the cash payment event to safeguard a high turnout rate.

Targeting

The project applied a four-step targeting mechanism, which combined geographical and categorical targeting approaches:

- First, the project geographically targeted the country’s regions with highest infant malnutrition rates as per the 2015 SMART survey and selected the Upper River Region, Central River Region and North Bank Region.
- Second, health facilities and their catchment areas within the regions were categorically selected. The project selected minor and major health facilities that were part of the MCNHRP. This approach was to ensure that BReST builds upon existing structures and acts as an extension to the MCNHRP’s component of cash transfer for pregnant women, thus reinforcing the impact using the first 1000 days of life approach.
- Third, Health facilities were selected according to the Global Acute Malnutrition (GAM) rates of their respective catchment areas. Following a ranking of the facilities, all facilities with a GAM rate below the national average of 5.5 per cent were dropped and the facilities with the highest GAM rates were selected. A total of 10 health facilities were selected.
- Fourth, women who have children under the age of five weeks within the catchment areas of the covered health facilities were targeted.

Registration and Enrolment Process

Lactating women with children under the age of five weeks in the targeted catchment areas were eligible for enrolment if mothers delivered their baby after the official launch date of the project and registered for the project within five weeks following the delivery date. Since women delivering within the health facilities as well as women not delivering in facilities were eligible for the project, there were two different trajectories for registration.

1) The first trajectory, through the health facility, concerned women who delivered in the health facility. Each selected health facility received a separate BReST register in which all women delivering at the health facility were registered. The Officers in Charge of the major and minor health centres submit a list of women who delivered in their respective health facilities. Actual validation, registration and enrolment of beneficiaries was then done during a registration event, which was combined with a payment day and took place on a monthly basis. Registration was completed on a device with the help of an electronic application (APP). After the digital registration process was completed and a picture of the beneficiary and her new-born taken, the newly registered beneficiary received her personal Cash
Transfer-card (CT-card). The plastic CT-card had a Quick Response code (QR-code) and by scanning this code access to the details of the beneficiary was granted. Upon completion of the registration process, the newly registered beneficiary, by showing her CT-card, was able to collect her first payment.

2) The second trajectory concerned women who did not deliver at a health facility. During the payment day, all women with new-borns wanting to enrol in the project approached the registration desk. Once the Officer at the registration desk verified that the respective woman’s name is not on the list from health facilities, the potential beneficiary was sent to the complaints and appeals desk, where her eligibility was verified. Once eligibility was confirmed, the woman was registered, and the same steps as outlined under the first trajectory were followed. In addition to registration, the woman was provided additional sensitisation, encouraging her to visit a health facility for prenatal consultation (PNC), growth monitoring and immunisation services.

The total number of women accepted in the project was based on the available budget, on a first-come, first-serve basis. Although the initial allocation was for 5,500 women, the number of actual recipients of the project went over the allocation, fluctuating between 5,556 to 5,898 women in the period of October 2017 to March 2019 when the project was in full operation. One reason for this was that project implementers felt that on the last day of registration, it was not possible to close registration once the maximum number has been met and turn down the rest of women who already came to register. They were able to keep the additional beneficiaries through efficiency savings and reallocations from unused funds.

Mobilisation and Sensitisation Activities

Mobilisation and sensitisation activities were organised to inform communities and potential beneficiaries about the project’s objectives, operations and logistical arrangements. The activities were conducted at national, regional and community level, prior to project inception, as well as throughout the course of the project’s implementation. At the national level, the activities included training of BReST project management team (PMT) members on the project objectives and advocacy meetings with high-level traditional and religious leaders. The regional level activities consisted of trainings for the regional and facility level project officials. The community level activities consisted of meetings with traditional and religious leaders and community members, along with broadcasting of radio messages. In addition, on a continuous basis, health workers sensitised women visiting health facilities about the project and its objectives and encouraged beneficiaries to stimulate other eligible women to enrol.

Project budget

The BReST project had a budget of 3 million euro. Of the total budget, 2,040,364 euro (68%) was allocated to Transfers and Grants to Counterparts (NaNA and Payment Institution) including around 50% of the total budget going directly to beneficiaries as cash transfers (BReST Interim Progress Report, 2019). Other input
budgets include supplies, commodity and materials (2.5% of total budget), staff & personnel cost by UNICEF (9.3%), contractual cervices (6.2%), travels by UNICEF (2.1%) and general operating costs and other direct costs (1.2%). Budgets for administrative costs incurred by UNICEF was 6.3% and contingency constituted 4.5% of the total budget.

2.3 Project Management and Coordination Structures and other stakeholders
The BReST project management, implementation and coordination framework was articulated across three levels – national, regional and health facility. The BReST management and coordination structure was integrated into the institutional framework of the MCNHRP. The National Nutrition Agency (NaNA) was the main implementing agency, given its experience with and involvement in the implementation of the MCNHRP.

National Level structures
At national level, coordination structures consisted of the Project Steering Committee (PSC) and the PMT, which were in line with the MCNHRP structure.

The PSC, hosted at the Office of the Vice-President, acted as a coordinating body of different stakeholders in the project and overlooked all entities in the project implementation. The PSC consisted of senior level representatives from the Vice President’s Office, Ministry of Finance and Economics Affairs (MOFEA), Department of Social Welfare (DSW), Ministry of Health and Social Welfare (MOHSW), Department of Community Development (DCD), Ministry of Agriculture (MOA), an NGO representative (the Gambia Family Planning Association -- GFPA), NaNA and a representative from UNICEF. The PSC reviewed project progress, outputs and constraints, and was in charge of approving the project workplans and budget, as submitted by the BReST PMT.

The PMT was responsible for the day-to-day coordination of the project implementation at national level. The structure of the BReST PMT was interwoven into existing government structures, and into the MCNHRP’s PMT and Rapid Response Team. The PMT was embedded in the National Nutrition Agency (NaNA). The DSW was also a member of this PMT, allowing for contributions and supervisions.

The BReST PMT consisted of six positions i.e. the Project Coordinator (PC) who was the Executive Director of NaNA; Project Facilitator (PF); Financial Management Specialist (FMS); Project Accountant (PA); Social Behaviour Change and Communication Manager (SBCCM); and Data and Case Management and Monitoring and Evaluation Officer (DCMMEO). With the exception of Data and Case Management and Monitoring and Evaluation, the aforementioned positions also existed within the MCNHRP PMT. Prior to the launch of the project, the members were provided with trainings and sensitisation on their positions’ functionalities.
Regional Level Structures

In line with MCNHRP, the Regional Directors of Health Services managed and coordinated the project at regional level. Other key actors at the regional level include the Health Promotion Officer and the Nutrition Field Officer who were jointly responsible for the mobilisation, nutrition education and sensitisation components of the project. Additionally, the Social Workers were responsible for all operational aspects of the project, including registration of beneficiaries, oversight of cash payments to the beneficiaries and oversight to the investigation of project misconduct. While one Social Worker per region was assigned for BReST, during the payment days two additional Social Workers provided assistance.

Facility Level Structures

At the health facility level, the BReST management and coordination activities involved the Officers in Charge (OIC) of the major and minor health centres, the Community Health Nurse (CHN) and the Payment Service Provider (PSP). The OIC Overlooked all CHNs within the catchment area and served as the interface between the CHN and the Regional Directors of Health Services. The OIC was also in charge of submitting all names of women that delivered at the health facility for registration purposes. The CHN was essential in communicating with and providing services to the women, including sensitisation and counselling related to the project.

The cash transfers were handled by a team of the National Association of Cooperative Credit Unions of The Gambia (NACCUG), which was selected as an independent PSP. The NACCUG travelled to each payment location on the payment days to deliver the money to beneficiaries.
Outside of the management and coordination structure above, other BReST stakeholders include (i) European Union as the project donor; (ii) other development agencies implementing relevant projects including the World Bank with its MCNHRP and WFP with its food supplementation project; and (iii) at village level, the VDCs, VSGs, village health workers and trained traditional birth attendants who are directly and/or indirectly contributing to the programme through on-going health education, outreach activities, and facilitating coordination at village level.

2.4 Theory of Change

The BReST project was based on evidence that demonstrates the advantages of specific nutrition interventions during the first 1000 days of the child (from conception to 24 months) on child’s present and future physical and cognitive development. These first 1000 days represent a unique window of opportunity when the foundations of optimum health, growth, and neurodevelopment across the lifespan are established (Cusick, Georgieff, Kok, & Yan, 2013). Some estimates suggest that focusing global efforts on nutrition in these 1000 days could reduce child mortality by 25% and neonatal death by 35% (Black et al., 2008). The 2003 Lancet Child Survival Series indicated that a combination of exclusive breast feeding...
with postnatal care could prevent up to 20% of under-five mortality in developing countries. Strong infant and young child feeding (IYCF) practice has proven to be the single greatest potential impact on child survival (Black et al., 2008). The BReST project targeted lactating women and under-two children in three of the poorest regions in the country in order to take advantage of this window of opportunity. The project had two main components: (i) a monthly cash transfer of 600 Dalasi to mothers of children less than 2 years old, and (ii) infant welfare clinics, IYCF and counselling sessions. Counselling session included, in addition to IYCF messages on WASH and on importance of vaccination and regular growth monitoring and family planning. The theory of change was reconstructed by the evaluation team during the assignment and is presented in the theory of change was reconstructed by the evaluation team during the assignment and is presented in Figure 3.

The cash transfer component, in the short run, increases household income, in particular women’s income and control over that income. Insufficient household income is one of the underlying causes of malnutrition. An additional income should enable the household to buy more diversified food. There is strong evidence from across Africa that social transfers are an effective and efficient way of achieving results in terms of food consumption and nutrition security (UNICEF, 2015a). Higher household income associated to better women’s knowledge, behaviour and skills in maternal, IYCF practices, was expected to contribute to building household’s capacity in addressing food/nutrition security, improve household’s diet quality and increase the quantity of food available and, therefore, improve nutritional status of mothers and their children. By increasing women’s control over income, cash transfers can also contribute to empowering these women. There is evidence that cash transfers can increase women’s decision-making power and choices, including those on marriage and fertility, and reduce physical abuse by male partners. In some cases, cases of emotional abuse of women were reported when the amount of the cash transfer was high (Hagen-Zanker et al., 2017). The evaluation team carefully scrutinized any effect of the transfer on women empowerment and gender relations in the household.

Infant welfare clinics and IYCF counselling sessions were the second and third components. During the clinics, anthropometric measures of children were taken in order to detect all malnourished children and enrol them in the competent services. Mothers were also educated in IYCF practices. These interventions took place during the payment day in the health centre. This was expected to have a positive impact on the use of health and nutrition services by women and children. Use of health services was, in turn, expected to mitigate the impact of disease (as the caregiver seeks medication) and reduce the prevalence of acute malnutrition (early identification of cases and treatment). Improved feeding and care practices, along with the use of health services was expected to contribute to improving child’s nutrition status and reducing child morbidity and mortality.
Figure 3. BRест Theory of change

**Impact**

Resilience building and improving nutritional status of lactating women and children under 2 in NBR, URR and CRR (A target of 10% decrease in acute malnutrition)

**Medium/Long-term outcomes**

- Women empowered
- Women involved in IGA

**Short-term outcomes**

- Increase in women’s income control
- Increase in household income

**Inputs & Activities**

- Monthly cash transfers to lactating women in health centers
- Infant welfare clinic

**Inputs & Activities (continued)**

- Infant and young child feeding and counselling sessions

**Intermediate Outputs & Activities**

- Improved household food security – Diet quality/quantity
- Building capacity of household in addressing food/nutrition security
- Increased number of registered children
- Identification and treatment of malnourished children
- Reduction of diseases

**Impacts**

- Improved children’s health status and reduction of child mortality and morbidity
- Improved women’s knowledge, behavior and skills in maternal, infant and young child feeding practices
- Improved feeding and care practices
- Improved children’s health status and reduction of child mortality and morbidity
- Improved feeding and care practices
Building resilience of beneficiaries was achieved through enhancing collaboration and synergy with other international organizations (World Bank, FAO, WFP) which are working on enhancing productivity in agriculture, food security, food supply chain and safety nets. By reducing the risk of child disease, the project also directly reduced the exposition of the household to this idiosyncratic shock.

One of the project unexpected outcomes was the increase in the number of registered births. In fact, birth certificate was one of the official identification documents requested by the program in order to receive payment. Other official identification documents included passports, national identification cards and voter cards. With support from the regional directors of health, beneficiaries could register and have the birth certificates issued for non-registered children, before receiving their payment. Birth registration is one of the first rights of the child as it enables her to exist legally.
3 Evaluation Methodology

The evaluation methodology rest on a four-pronged approach encompassing: (i) the equity-based and human-rights approach, (ii) the life cycle approach, (iii) the economic approach, and (iv) the participatory approach (See annex 2 for details on different approaches).

The evaluation relied on the use of mixed methods (qualitative and quantitative) to address each one of the envisaged evaluation questions. The mixed approach was particularly effective in that it made it possible for the evaluation team to reach measurable and relevant conclusions based on a triangulated interpretation of the results. The mixed-method approach favoured, on the one hand, the quest for quantifiable and precise results through the collection of first-hand quantitative data, and on the other, the analysis of the validity and the interpretation through the testimonies collected from stakeholders at all levels.

3.1 Qualitative methods

The purpose of the qualitative component was to gather information from the project stakeholders and beneficiaries to understand their unique experiences in being part of the project.

Besides the conduct of semi-structured interviews with the project expected beneficiaries, a number of exchanges were held with service providers (including social workers and health and nutrition officers) to gauge their knowledge and understanding of the dynamics affecting both the beneficiaries’ utilisation patterns and their reactions to the project activities. The Annexes 7 to 13 of the report showcase the interview guides used for KIIs and FGDs, and annex 17 and 18 present the detailed plan of the field visits organized during the data collection phase.

The documentary review exploited the existing programmatic documents and was complemented by primary data collection through focus group discussions, key informant interviews and field observations. The following sections (from 3.1.1 to 3.1.5) present qualitative methods used in the evaluation (for more details and a full description of the methods summarised below, please consult Annex 6).

3.1.1 Documentary review

The documentary review relied on the analysis of two different types of resources: (a) key background documents that helped to contextualize the project, as well as (b) project documents outlining:
i) The specific intervention context and the programmatic objectives;
ii) The characteristics of the project target population and its environment;
iii) The project key operational features (targeting, design, operations and procedures).

In addition, the desk review allowed the team to better understand the link existing between the project and a similar World Bank-led project as well as between the project and the national institutional framework.

The desk review also examined contextual information on the nutritional status of women and children as identified by the World Bank's MCHNRP project during the mid-term evaluation\(^2\). In the absence of a baseline for the BReST project, this data provided a rather solid evidence base to better understand the vulnerability of the population groups covered by BReST.

### 3.1.2 Key informant interviews

A series of individual key-information interviews were organized face-to-face and remotely during the inception phase and field missions in-country. Key informants from national and regional level as well as development partners were identified through purposive sampling based on information provided by UNICEF Gambia office. The detailed list of key informants and the number of interviews performed is presented in Table 2.

<table>
<thead>
<tr>
<th>No</th>
<th>Key Informants Interviews</th>
<th>Female</th>
<th>Male</th>
<th>No. of interviews</th>
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<td>1</td>
<td>UNICEF, Social Protection Officer</td>
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<td>1</td>
<td>2</td>
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<tr>
<td>2</td>
<td>NACCUG, Finance and Admin Officer</td>
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### No. Key Informants Interviews

#### National level

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<td>7</td>
<td>Ministry of Health, Deputy Permanent Secretary</td>
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<td>0</td>
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<td>8</td>
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<td>10</td>
<td>Vice President Office, Deputy Permanent Secretary and National Social Protection Coordinator</td>
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#### Regional level

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<td>Regional Health Director (RHD)</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12</td>
<td>Regional Social Workers</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

#### Development partners

<table>
<thead>
<tr>
<th>No</th>
<th>Key Informants Interviews</th>
<th>Female</th>
<th>Male</th>
<th>No. of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>The World Bank, Focal Point for Maternal and Child Nutrition and Health Results Project</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>The European Union Delegation – Programme Manager</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Total: 6 females, 25 males, 29 interviews

1. Some persons were interviewed more than once and during some interviews more than one person has been present – hence the difference in the sum.

#### 3.1.3 Focus group discussions

In order to reach an adequate triangulation of evidence, the evaluation team conducted 40 focus group discussions (FGD) at the local level with beneficiaries, beneficiaries’ spouses, VDCs; VSGs and local health personnel as per the table 3.

The total number of FGD and sites chosen for hosting them was agreed upon with the UNICEF Country Office staff, based on a number of diverse criteria. In addition, a specific effort was made to allow that the data collection sites be as representative as possible of the health facility catchment areas (that is, of the ten sites covered by the project in its three targeted
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

regions. In the absence complete beneficiaries’ databases, the evaluators applied purposive sampling when selecting beneficiaries to be part of focus groups. Selection process was locally supported by Village Development Committees (VDCs) and Village Support Groups (VSG). In addition, most FGD were conducted in community spaces.

### Table 3. Focus group discussions organized during the evaluation

<table>
<thead>
<tr>
<th>No</th>
<th>Focus Group Discussions</th>
<th>No. of FGD</th>
<th>Female</th>
<th>Male</th>
<th>No. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Village Development Committees (VDCs) and Village Support Groups (VSGs)</td>
<td>13</td>
<td>40</td>
<td>64</td>
<td>104</td>
</tr>
<tr>
<td>2</td>
<td>Officer in charge of HF and Community Health Nurse</td>
<td>7</td>
<td>12</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td>3</td>
<td>FGDs with Beneficiaries</td>
<td>10</td>
<td>100</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>4</td>
<td>FGDs with Beneficiaries’ spouses and village leadership</td>
<td>10</td>
<td>0</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Community Space in Demba Kunda, Upper River Region used for the Focus Group Discussions.

3.1.4 Field Observations

Direct observation is a key triangulation method to counterbalance data from testimonies or statements stemming from other evaluation sources. As part of the evaluation process, the team used observation in a non-obstructive manner in the following situations:
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

- During the stakeholder interviews held with the national implementing agency, the evaluation team observed the monitoring performed in SCOPE in the course of a demonstration done by the information technology (IT) team;
- At the health facilities where the majority of services are provided to the BReST beneficiaries, the evaluation team observed the records held by the personnel;
- At the local level, in the beneficiaries’ households, the evaluation team carried out observations during the quantitative survey. In this case observations were systematized in the questionnaire.

3.1.5 Qualitative data analysis

All qualitative materials -- interviews and focus groups -- were recorded and transcribed by the local evaluation team members and notes were also taken by the international evaluation team member facilitating the interviews/discussions. The evaluation team based the analysis on a rigorous notetaking and review of all transcriptions. In addition, the data collected in the three regions were discussed internally at the end of each field missions to assess the content and identify the singularities of each site. Exhaustive and methodic notetaking made it possible to identify the key moments of each interviews/ focus group discussion and the relevant quotes used for this report.

3.2 Quantitative methods

In addition to administrative data from the project monitoring and evaluation system, primary quantitative data was collected in order to assess if the project produced the intended effects and impact on its beneficiaries.

This evaluation follows a post-project design with a non-randomized comparison group. The data collected serves mainly to compare BReST beneficiaries to non-beneficiaries at the end of the project, in areas covered by the Maternal and Child Nutrition and Health Results Project (MCNHRP). Both treatment and comparison groups are indeed MCNHRP recipients.

A sample of 326 respondents was drawn (with 95% confidence interval and 2.5% margin of error). All ten Health Facilities (HFs) under the BReST project were visited. Five comparison HFs were selected. The comparison group is composed of HFs which benefited from the MCNHRP but not from the BReST project, and in which there is no BReST beneficiary. The respondents in each HF were randomly selected. The individual respondents were mothers of children less than 3 years old. Table 4 presents the distribution of respondents in comparison and treatment groups. For a detailed description of survey sampling, please refer to Annex 15.

3 To estimate the actual sample size, STATA command power was used with the following information: a margin of error of 5%; a desired level of power of 80%; a balanced sample size between comparison and treatment groups, and a common standard deviation of 1.
Table 4. Sampling frame

<table>
<thead>
<tr>
<th>Regions</th>
<th>HF catchment areas</th>
<th>Treatment/comparison</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>North Bank Region</strong></td>
<td>Ngayen Sanjal</td>
<td>Treatment</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Essau</td>
<td>Treatment</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Kuntair</td>
<td>Treatment</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Albreda</td>
<td>Treatment</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Kerr Cherno</td>
<td>Comparison</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Farafenni</td>
<td>Control</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td><strong>Total treatment</strong></td>
<td></td>
<td><strong>85</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total comparison</strong></td>
<td></td>
<td><strong>85</strong></td>
</tr>
<tr>
<td><strong>Central River region</strong></td>
<td>Brikamaba</td>
<td>Treatment</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Dankunku</td>
<td>Treatment</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Kudang</td>
<td>Treatment</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Kuntaur</td>
<td>Treatment</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Bansang</td>
<td>Comparison</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Sami</td>
<td>Comparison</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td><strong>Total treatment</strong></td>
<td></td>
<td><strong>50</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total comparison</strong></td>
<td></td>
<td><strong>50</strong></td>
</tr>
<tr>
<td><strong>Upper River region</strong></td>
<td>Demba Kunda Koto</td>
<td>Treatment</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Basse</td>
<td>Treatment</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Fatoto</td>
<td>Comparison</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td><strong>Total treatment</strong></td>
<td></td>
<td><strong>28</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total comparison</strong></td>
<td></td>
<td><strong>28</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total sample size</strong></td>
<td></td>
<td><strong>326</strong></td>
</tr>
</tbody>
</table>

The paper-based survey was administered in December 2019, using a questionnaire developed specifically to catch the impacts and effects of BReST (see Annex 16 for the questionnaire). Prior to the actual data collection, the questionnaire was piloted in Brikama West Coast Region (WCR), on November 1st, 2019, and some adjustments were made in order to adapt the questionnaire to the local context and specificities. To this end, 16 enumerators and 3 supervisors were trained to collect data during the first week of December 2019.

Data were analysed using the statistical software STATA. The results were corroborated and triangulated with the qualitative data and secondary data (MICS 2018, SMART 2015, and project administrative data) in order to provide valid conclusions.

### 3.3 Limitations and challenges of the qualitative and quantitative methods

<table>
<thead>
<tr>
<th>Limitations</th>
<th>Strategies to Overcome/Mitigate them</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.Absence of a baseline</strong></td>
<td>The main limitation of the analysis is the absence of a baseline data. To compensate for that, in addition to the use of a comparison group in the quantitative survey, several covariates variables susceptible to influence the impact of the project were added to the regressions.</td>
</tr>
<tr>
<td>2. Absence of observation of key interactions such as activities during Payment days</td>
<td>Since the evaluation started after the last payment of BReST beneficiaries was completed, the evaluation team could not observe the activities during a standard payment day and, therefore, could not appreciate the plurality of practices associated with such occurrence (the payment delivery, the awareness-raising of beneficiaries on health and nutrition practices, the handling of complaints, the collection of monitoring health indicators as well as other sensitive cases by social workers). In order to retrace part of what happens in a regular payment day, in addition to asking for a description of the latter to the involved stakeholders, the team of evaluators analysed the books containing the payment details held within the health facilities and the reports drafted by social workers. In addition, the team analysed the payment spreadsheets facilitated by the NGO in charge of providing the cash transfer.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3. Recall bias</td>
<td>Given that part of the interview guide prompted the respondents to reflect on their past experiences, interviewees may have reported their experiences with a certain degree of inaccuracy, or rather chosen or preferred to recall certain information instead of others. To overcome such bias, the multiplication of interactions with Social workers, health personnel and NaNA at the regional level, then with the implementing agency at the national level (NaNA) has made it possible to point out possible problems, dysfunctions or conversely, positive points that would not have been mentioned.</td>
</tr>
<tr>
<td>4. Perceptions bias</td>
<td>Focus group discussions held with the beneficiaries are conducive to capture a general assessment of the impact produced by the project. However, the actual impact can only be established in light of measurable indicators. Triangulation with quantitative data results allowed overcoming this bias.</td>
</tr>
<tr>
<td>5. Causality determination</td>
<td>The BReST project has been designed in conjunction with other projects. From a methodological point of view, this poses a major challenge to the evaluation, which is that of isolating the effects of BReST with respect to the effects of other projects such as MCNHRP. In order to overcome this challenge, the quantitative component has been designed to discern the effects of BReST in contrast to the effects of other projects. In particular, the evaluation was designed to capture only the value added by the BReST project to the MCNHRP, as described in the subsection on quantitative methods.</td>
</tr>
</tbody>
</table>
### 6. Language and cultural barriers

Since focus group discussion held with community members have been conducted in the local language and facilitated by one of the local evaluators, the translation may have induced data accuracy gaps. In order to overcome this problem, local evaluation team, proficient in local languages, were coached for a day in facilitating FDGs, commenting on the content of the guides and simplifying questions when needed.

### 3.4 Ethical Considerations

The evaluation design is based on a number of interactions with BReST stakeholders, including government members at the national and regional levels participating in the implementation of the project, service providers, United Nations System Organizations, cooperating partners and final beneficiaries.

Strict compliance with the UNEG Ethical Guidelines (UNEG, 2008), and the UNICEF Procedures for Ethical Standards in Research, Evaluation and Data Collection and Analysis (UNICEF, 2015b) was ensured during all the stages of the evaluation (inception, design, tools development, data collection and analysis, and reporting/dissemination). The key considerations included:

- Independence, impartiality and credibility of evaluation judgements
- Accountability and utility of evaluation
- Respect and protection of the Human Rights and Gender Equality
- Conflicts of interest

Obtaining informed consent, protecting anonymity and privacy of respondents, storage of data, and responding to child protection concerns were key at all stages, especially during the data collection process. Ethical guidelines were incorporated either upstream or in the questions included in the data collection instruments. They were given special attention during the training phase of local team who accompanied the data collection.

For interviews with key informants, the role of the evaluation team and the purpose of the evaluation were presented prior to the exchange. The consent of the interlocutor and the guarantee of confidentiality were agreed before the initiation of the dialogue. Similarly, during the quantitative data collection process and the FDGs, written informed consent was obtained from every respondent before anyone is allowed to take part in the survey and the FDGs. The data collection tools used were developed using universally approved indicators and ensured the use of respectable language taking into consideration the culture of the participants.
4 Evaluation findings and Preliminary Conclusions (by criterion)

This section presents findings and preliminary conclusions by criterion. The evaluation team has answered all the evaluation questions and numbered all the findings’ paragraphs. The preliminary conclusions are located and boxed at the end of each section. In order to ensure relevance and credibility, the evaluation team also referenced each of the preliminary conclusions with findings’ paragraph numbers on which the conclusions are based.

4.1 Relevance

**EQ 1.1.** To what extent are the BReST Project’s interventions aligned with the Gambia Government identified priorities (i.e. National Social Protection Policy & National Development Plan)?

**EQ 1.2.** To what extent does the BReST project respond to the identified needs among its expected beneficiaries?

**EQ 1.3.** How complementary are the UNICEF BReST interventions with those implemented by the World Bank, government and other partners to reach the most vulnerable?

**EQ 1.4.** To what extent were the Project’s expected results clearly stated and measurable through identifiable indicators and disaggregated by sex and age?

**EQ 1.5.** To what degree were the project interventions based on a thorough review of cultural and social norms?

Illustration 1. Immunization schedule hanging at the Health Facility among BReST sensitization materials (@UNICEF Gambia / 2019)
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

EQ 1.1. To what extent are the BReST Project's interventions aligned with the Gambia Government identified priorities (i.e. National Social Protection Policy & National Development Plan)?

1. The design of BReST is fully in line with the objectives of the National Development Plan, under Objective 3 “Investing in our People through improved education and health services and building a caring society”. The BReST project is designed as a continuation of the MCHNRP project, which itself has detected the areas of highest nutritional vulnerability including the Upper River, the Central River and the North Bank West Regions and concentrates one-third of the country's population (World Bank, 2018). The BReST project is explicitly mentioned in the National Development Plan (2018-2021) as a key intervention aimed at building resilience provide safety nets to address vulnerabilities.

2. The BReST project was established to improve the nutritional status of children under 2 years old in the most disadvantaged population groups of the country, thus contributing to the long-term goal of "protecting, preventing, promoting and transforming the lives of the poorest people" and the most vulnerable "in the country (NSPP 2015-2025). The design of the project contributes to putting in place progressive coverage of social protection policies as established in the Social Protection Implementation Plan (IP) to achieve the objectives of the NSPP.

3. The BReST project has also contributed to the achievement of health goals in the National Health Policy (2012-2020) targets. The latter identifies among the socio-economic determinants of access to care poverty and a lack of education leading to "ill-health". As reported in more detail in the later sections, by focusing on mothers and children under two, the BReST project in synergy with the MCHNRP project has promoted the use of services and the change of behaviour in respect to the frequency of health consultations.

EQ 1.2. To what extent does the BReST project respond to the identified needs among its expected beneficiaries?

4. The design of the project is relevant and specifically targets the most vulnerable regions. Project coverage allowed targeting just under 6,000 mothers and new-borns in 10 selected priority health zones in the North Bank (NBR), Central River Region (CRR) and Upper River Region (URR) regions. The design of the program includes counselling on key health, nutrition and hygiene practices to reach an optimal behavioural change.

The project is designed to contribute directly and indirectly to the objectives set out in the National Development Plan, through a cross-sectoral mechanism including:

i) A categorical approach promoting the realization of women and children’s rights.
BReST is based on a categorical targeting allowing mothers and children covered by the scope of its action to benefit from social protection mechanisms. By focusing intervention on the first years of life, BReST promotes the realization of their rights and their potential.

ii) A holistic view on malnutrition and maternal health encompassing several dimensions of well-being:

BReST follows in the footsteps of the MCHNRP by placing a critical importance on delivering in health facilities as the first eligibility clause, and secondly on optimal nutrition and care for babies in their first 1000 days from conception. It is expected that the articulation between the behavioural change component and the grant of the benefit has a structuring effect on nutritional and health practices and on the appropriate use of the social transfer. Monthly education on health, hygiene and nutrition issues combined with individual counselling in the reproductive and child health clinics (RCH) provide an overall support to mothers enrolled in BReST.

iii) A focus on the supply of services:

The project is in line with the healthcare offer provided by the MCHNRP project (detailing the offer of care) and structures its activities around the health facility thus making it possible to match supply and demand.

iv) A focus on education and behavioural change

The social and behavioural change strategies accompany the other sub-components to take a comprehensive and sustainable approach to promoting behaviour change and increasing the demand for health care utilization.

5. The evaluation team was not informed of any beneficiaries needs assessment carried upstream or during the project implementation. However, based on the opinion of the beneficiaries and local communities, the evaluation team confirms that BReST contribution responds to their needs. As such, the majority of the beneficiaries interviewed in the field admit having appreciated and applied the main counselling messages delivered by BReST concerning exclusive breastfeeding, food diversification after the 6 months of their children’s life, as well as the importance of colostrum, among others. Monthly support, individual counselling and health talks along with the monetary benefit are acknowledged to respond directly to the mother’s health and financial needs. Mothers recognize that the monthly transfer of 600 dalasi is sufficient to encourage specific purchases for babies’ needs.
Evaluator: “So, does the availability of the services in the different projects (BReST, MCHNRP) improve the health of the children?”

Interviewee: “Exactly! it has improved the health of beneficiaries’ children because they get used to going the health facility regularly and also taking their kids for regular anti-natal checks and everything, post-natal care. These are all important things BReST has boosted up”.

Interview with National Stakeholder, October 28th, 2019.

6. With a few exceptions, the evaluators found an ideal synergy between the functioning of the MCHNRP and BReST. Indeed, BReST beneficiaries were previously supported by the project (MCHNRP) during their pregnancy, and thus 93% of them gave birth in a health facility. BReST is a logical follow-up to MCHNRP since it focuses on improved nutrition and care practices during the first 2 years of the same mothers and children, that have been supported by the MCHNRP during pregnancy. By attaining the objective to increase the efficiency of the health system and to strengthen the link between health facilities and communities served, MCHNRP set a favorable environment to roll out BReST. As far as the cash component is concerned, the BReST project ensured that the beneficiaries of the MCHNRP cash component (a 1000 dalasi- benefit intended to help the most vulnerable families for the creation of small income-generating activities) are not included as beneficiaries of BReST to avoid duplication.

7. As far as the beneficiaries are concerned, continuity in the support ensures that the dialogue between local actors and mothers was not disrupted, allowing for an adequate support during prenatal and postnatal periods. An example of continuity can be found in the consistency of the messages delivered by the two interventions as BReST capitalized and reused MCHNRP communication materials aimed at improving nutrition and health, for mothers and their babies.

8. All the interlocutors interviewed, in particular the medical staff, affirm that there is a strong compatibility between BReST, the MCHNRP and regular health interventions. The MCHNRP project acts upstream of BReST. Indeed, the MCHNRP aims to increase the use of community nutrition and primary maternal and child health services and to strengthen ties with the local communities. BReST benefits from the strengthening of health services promoted by the MCHNRP since the perimeter covered by BReST is within the wider perimeter covered by MCHNRP. In addition, BReST benefits from the organizational structures at the local level promoted by MCHNRP (the VSGs and the VDCs) which relay key messages and help operationalize the project.
9. Synergies with the WFP interventions were identified at various levels. First of all, given that the BReST project covers a limited number of beneficiaries, WFP’s action aimed at providing pregnant women in the second and third trimesters of pregnancy with nutritional supplementation comes in support to those mothers that could not be part of BReST. Similarly, during payment days, when BReST agent come across a child suffering from moderate (MAM) or severe malnutrition (SAM), the mother and child are immediately referred to an additional targeted supplementary feeding (TSF) supported by the WFP, in collaboration with the MoHSW.

There is also a complementarity of both programs at the PMT level since BReST beneficiary database uses the SCOPE management tool which is under the responsibility of WFP. This sharing of the application greatly facilitated the rapid insertion of beneficiaries into a centralized register.

Illustration 2. Shared use of SCOPE software (by WFP and BReST Monitoring staff) for recording beneficiary data

10. Synergies are also observed in the mutualization of human resources at the national level. Effectively, both MCHNRP and BReST projects are being implemented under the leadership of the National Nutrition Agency (NaNA) and the Ministry of Health and Social Welfare (MoHSW). The simultaneous implementation of the two interventions facilitates the emergence of institutional in-country expertise that can be mobilized for other effects.
EQ 1.4. To what extent were the Project's expected results clearly stated and measurable through identifiable indicators and disaggregated by sex and age?

11. In line with the remarks made by a previous EU evaluation (EU, ROM, 2018), this evaluation notes that the measurable indicators of the project are set under the overall objective of the project and under the first specific objective (SO1). The indicator of the global objective refers to the reduction of acute nutrition malnutrition up to 10% for children under 2 years being followed by the project in the referred regions of North Bank Region (NBR), Upper River Region (URR), and Central River Region (CRR) project.

12. This indicator can be easily monitored by measuring the mid-upper arm-circumference (MUAC) of children beyond 6 months. The evaluation team confirmed that this measurement was carried out regularly during BReST payment days for babies of beneficiary mothers. Effectively, MUAC was reported under the routine monitoring data, jointly with deworming and vitamin A supplementation. The evaluators noted, however, that there are significant variations in the way MUAC is tracked: in some health facilities the officer in charge would indicate that the measure has been taken, in others, the officer would report the exact value for the MUAC measurement. Such discrepancies in the data entry make centralization and its subsequent analysis difficult. Similarly, the evaluators observed no disaggregation by sex of the data concerning the children in all the implementation sites, visited during the fieldwork, with the exception of Demba Kunda Koto.

13. The sole indicator for SO2 ("improved implementation of related Government Policies through building capacities of government partners and civil society organizations") is formulated in quite general terms and, as such, it does not lend itself to being easily measured. Admittedly, the evaluators noted that all interlocutors have a positive perception of the gain in knowledge and increase in capacity and ownership in the implementation of the project. However, as the skills actually acquired by the trained project beneficiaries are not subject to any systematic evaluation, it proves difficult to make any inference with respect to such indicator. In addition, actors targeted by capacity building activities were insufficiently specified. That notwithstanding, this indicator remains particularly important in a context of high attrition as stated during the interviews with the PMT.

EQ 1.5. To what degree were the project interventions based on a thorough review of cultural and social norms?

14. Interviews with the key informants did not allow the evaluation team to conclude that an exhaustive analysis of the social and cultural norms preceded the project implementation. It seems that this aspect was not a BReST priority neither during the design phase nor during the early stages of implementation. Yet, it is acknowledged that analyzing the internal dynamics of local communities can greatly contribute to assess the complexity of
barriers in fulfilling fundamental rights. As far as gender is concerned, for instance, recent studies highlight how discriminatory social norms and practices lead to a restriction of women’s rights and empowerment opportunities (Bouchama et al., 2018). As such, the evaluation team noted that the dynamics of social stratification in The Gambia exist, especially in the province of URR with the prevalence of a caste system and may be responsible for limiting the positive effects at the direct beneficiaries’ level, particularly in terms of decision-making power of women (Musukuta et al., 2019). The patriarchal structure of rural communities is certainly recognized in the project design, but no component of the project directly addresses its impact on the socioeconomic vulnerability of the targeted populations nor in the intra-household relationships.

15. In areas more directly related to BReST including children’s health and nutrition and women’s reproductive health, the project, in synergy with MCHNRp, considered social norms, habits and practices leading to the low use of health services and family planning. Awareness activities and behavioral change materials used with beneficiaries attest to a certain level of knowledge of local habits and beliefs that may create barriers to access the health services. During the FGD, beneficiaries and the local communities acknowledged the interest and relevance of the information received during the sensitization campaigns. They unanimously agreed that, while respecting their tradition, BReSt pointed out harmful practices based on common beliefs and proposed appropriate practices in replacement. Both women and men readily quoted the messages on meal preparation, food preservation, breastfeeding as examples they now apply.

“Before BReST we would throw the colostrum away. Thanks to BReST, we now know it’s important for our babies”
Beneficiary in Sare Paresu, URR Region

PRELIMINARY CONCLUSIONS: RELEVANCE

REL1: The design of BReST is fully in line with the objectives of the National Development Plan. It contributes to the achievement of health goals under the National Health Policy (2012-2020) targets and to the achievement of a progressive coverage of social protection policies as established in the Social Protection Implementation Plan (IP) to achieve the objectives of the NSPP. The direct target groups of this action were about 6,000 mothers of newborn babies, in 10 selected priority health areas in NBR, CRR and URR. Geographical targeting allowed the project to address the most vulnerable persons to the achievement of health goals under the National Health Policy (2012-2020) targets and to the achievement of a progressive coverage of social protection policies as established in the Social Protection Implementation Plan (IP) to achieve the objectives of the NSPP. The direct target groups of this action were about 6,000 mothers of newborn babies, in 10 selected priority health areas in NBR, CRR and URR. Geographical targeting allowed the project to
address the most vulnerable persons as malnutrition prevalence is higher in these regions [Par 1-4].

**REL2:** The design of the project is sound and provides a comprehensive response to nutrition and health issues. Mothers are encouraged to learn more about improved nutrition and health, both for themselves and for their children, as well as new and improved practices. The benefit directly responds to the mother’s financial needs offering a monthly income of 600 dalasi which mothers were encouraged to use for babies’ needs [Par 4-5].

**REL3:** BReST is a logical follow-up to MCNHRP since it focuses on improved nutrition and care practices during the first 2 years of the same mothers and babies, that have been supported by the MCNHRP during pregnancy. Both interventions are coherent and complementary and provide a complete support during the full first 1000 days of the life [Par 6-8]. BReST works in synergy with WFP interventions: for those pregnant women not benefiting from BReST, the WFP would facilitate nutritional supplementation during the second and third trimesters [Par 9].

**REL4:** Indicators used to monitor results are of variable quality. While the main indicator for malnutrition, can easily be monitored through MUAC measurement, the strengthening of institutional capacities remains imprecise and cannot be verified within the framework of the project [Par 10-12].

**REL5:** BReST is not based on an exhaustive analysis of social norms and habits, especially when it comes to gender dynamics and informal institutions. The latter clearly did not seem to be a priority at the start of the project. Concerning the norms and habits related to nutrition and health education, the implementation of BReST shows that local behavior was taken into account and specifically targets behavioral change [Par 13-14].
4.2 Impact

**EQ 2.1.** Is there any lasting change that could be identified with regards to the health and nutrition of women and children in the BReST project?

**EQ 2.2.** To what extent has the project contributed to increasing beneficiary households’ resilience to income shocks?

**EQ 2.3.** To what extent has the BReST project increased identity documents in the targeted communities?

Illustration 3. A Public Health Officer in NBR explains mother and child health trends in a Health Facility since the inception of the BReST project (@UNICEF Gambia / 2019)
EQ 2.1. Is there any lasting change that could be identified with regards to the health and nutrition of women and children in the BReST project?

**Prevalence of global and severe acute malnutrition**

16. Severe acute malnutrition (SAM), moderate acute malnutrition (MAM) and global acute malnutrition (GAM), are estimated using the MUAC measurement for children more than 6 months old. Following WHO cut-offs, SAM is defined as a MUAC of less than 11.5 cm, MAM as MUAC between 11.5 and 12.5 cm and GAM as a MUAC of less than 12.5 cm.

17. At Health Facility catchment area level, the evaluation analysed data from The Gambia National Nutrition Surveillance in March 2016 and March 2019 to assess changes in child malnutrition status in BReST HF catchment areas and Non-BReST HF catchment areas in the same regions. The National Nutrition Surveillance uses the same MUAC measurement to determine SAM and MAM and is conducted every six months (March and September) to account for seasonality. The National Nutrition Surveillance was used as a reference to determine BReST target regions based on the high malnutrition rate.

18. Based on the surveillance data, between 2016 and 2019, child acute malnutrition has decreased in all regions in the Gambia except for North Bank Region East (Figure 4). Malnutrition rate increased between 2016 and 2019 in almost all HF catchment areas in NBR East. Interestingly, the only HF catchment area making improvement in NBR East is Ngayen Sanjal, which is the only BReST targeted HF in that health region (Figure 5). While SAM and GAM in other areas in the region significantly increased, SAM in Ngayen Sanjal has declined from 1.8% in 2016 to 1.2% in 2019 (a reduction of 0.6 percentage point). The area’s GAM rate experienced a 0.3 percentage point reduction. This finding is consistent with information obtained in KII and FGDs at regional level, where Ngayen Sanjal was praised as the best performing health facility in the region.
A similar pattern, albeit less stark, is seen in Upper River Region. On average, health facilities targeted by BReST performed slightly better. Basse had the highest GAM reduction compared to other HFs in the region (Figure 6). GAM reduction in Basse between 2016 and 2019 was 3.0 percentage points while the reduction in Koina, GambiSara, Fatoto and Yerobawol in the same period ranged between 1.2 to 2.8 percentage points respectively. Two other non-BReST facilities, Baja Kunda and Daibungu, in the same period experienced an increase in GAM by 0.7 and 3.3 percentage points respectively.
20. The rest of the BReST targeted regions, North Bank West and Central River Region, do not show significant differences between BReST and non-BReST HF catchment areas (Figure 7 and Figure 8). All areas in NBR West show significant acute malnutrition reduction and areas in CRR generally show reduction except for small setbacks in Dankunku (BReST area) and Kaur (non-BReST area).

21. Looking at the BReST administrative data, prevalence of GAM and SAM among BReST beneficiaries in general decreased between February 2018 and September 2019, as shown by Figure 9. This improvement in nutritional status may be due to the project in combination with other developments (acute malnutrition decreased in general even in non-BReST areas as previously discussed), but also to age, as older children tend to be less at risk of acute malnutrition.

Figure 9 Evolution of global and severe acute malnutrition among BReST beneficiaries
22. When comparing the treatment and the comparison groups after the end of the project (survey conducted in December 2019), by also controlling for women and household characteristics\(^4\) and prevalence of acute malnutrition in health facilities in 2016\(^5\), there is no evidence that the BReST project had a significant effect on the prevalence of GAM and SAM (these results apply to both boys and girls). Since the survey was conducted a few months after the cash transfer had stopped, the lack of a significant difference between the treatment and comparison group may be explained by the fact that the cash transfers had stopped: as long as cash transfers were provided previously, they were associated with improvements in nutritional status among BReST beneficiaries.

23. This is supported by findings on minimum dietary diversity (below) \(^6\). Although minimum dietary diversity during the project was found to be significantly higher among BReST beneficiaries compared to the rest of the population, post-project survey found that BReST beneficiaries do not necessarily provide their children with more diversified food and at higher frequency compared to non-beneficiaries. Information extracted from FGDs with beneficiaries and beneficiaries’ spouses attested that that the monetary support provided by BReST was essential in helping families purchase additional and more diversified food, but these families struggle to maintain such consumption pattern once the cash transfer has stopped.

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\(^4\) Health facility, region, if the woman receives other cash transfers, woman’s age, ethnicity, education, household size, gender of the child, age of the child, proportion of sam and mam in 2016 in the health facility catchment area, if head of household is involved in IGA.

\(^5\) We used data from The Gambia National Nutrition Surveillance, collected in March 2016.

\(^6\) Minimum dietary diversity refers to the percentage of children between 6 and 23 months receiving 4 or more of the following food groups during the previous day: 1. grains, roots and tubers; 2. legumes and nuts; 3. dairy products (milk, yogurt, cheese); 4. flesh foods (meat, fish, poultry and liver/organ meats); 5. Eggs; 6. vitamin A rich fruits and vegetables; 7. other fruits and vegetables.
Infant and Young Child Feeding practices

24. **Exclusive breastfeeding.** UNICEF and WHO recommend exclusive breastfeeding until the age of 6 months. Exclusive breastfeeding means that the child receives only breast milk, and no other liquids and solids with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines (WHO, 2019). Exclusive breastfeeding benefits both the mother and the child. Breast milk contains all the nutrients that an infant need in the first 6 months of life. Breastfeeding protects against diarrhoea and common childhood illnesses such as pneumonia and may also have longer-term health benefits for the mother and her child, such as reducing the risk of overweight and obesity in childhood and adolescence.

25. The proportion of mothers who exclusively breastfed their child when the child was less than 6 months is significantly higher among BReST beneficiaries compared to the comparison group, as shown in Figure 10. Among BReST beneficiaries, 93% of children were exclusively breastfed, against 86% in the comparison group. The data shows a positive and significant effect of the project on exclusive breastfeeding. When looking at the disaggregated data, the rate of exclusive breastfeeding and the effect of the project vary by region. In NBR and CRR, the rate of exclusive breastfeeding is higher among BReST beneficiaries, while the opposite is true in URR. More efforts in term of sensitization to exclusive breastfeeding are needed in URR, particularly in Basse.

![Figure 10. Proportion of exclusive breastfeeding](image)

Source: Project endline survey

26. When comparing the proportion of BReST mothers who exclusively breastfed their child against the population using the MICS 2018, the evaluation team found that the proportion of exclusive breastfeeding is significantly higher among BReST beneficiaries, as shown in Table 5. While only 55.2% of children under the age of 6 months were exclusively breastfed in the country (MICS 2018), this proportion reaches 91% among BReST beneficiaries.
Table 5. Exclusive breastfeeding rates amongst BReST beneficiaries vs the entire population

<table>
<thead>
<tr>
<th>Region</th>
<th>BReST beneficiaries (December 2019)</th>
<th>Average in the population (MICS 2018*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Bank Region -- NBR</td>
<td>93%</td>
<td>54.30%</td>
</tr>
<tr>
<td>(Kerewan LGA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central River Region -- CRR</td>
<td>98%</td>
<td>53.80%</td>
</tr>
<tr>
<td>Kuntaur LGA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Janjanbureh LGA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper River Region -- URR</td>
<td>82%</td>
<td>55.60%</td>
</tr>
<tr>
<td>(Basse LGA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National rate</td>
<td></td>
<td>55.20%</td>
</tr>
</tbody>
</table>

Source: MICS 2018 and project endline survey

*MICS 2018 data were collected between January and April 2018.

27. **Minimum dietary diversity.** Minimum dietary diversity refers to the percentage of children between 6 and 23 months receiving 4 or more of the following food groups during the previous day: 1. grains, roots and tubers; 2. legumes and nuts; 3. dairy products (milk, yogurt, cheese); 4. flesh foods (meat, fish, poultry and liver/organ meats); 5. Eggs; 6. vitamin A rich fruits and vegetables; 7. other fruits and vegetables. The minimum dietary diversity was significantly higher among BReST beneficiaries than in the population. According to the MICS 2018, only 18.6% of children between 6 and 23 months received the minimum diversity of meals/snacks during the previous day in the Gambia. This proportion exceeded 50% for BReST beneficiaries in all the 3 regions where the project was implemented. In Basse LGA for instance, only 16% of children between 6 and 23 months received the minimum diversity of meals, against 52.4% among BReST beneficiaries in the same area (see Table 6).

Table 6. Minimum dietary diversity, BReST beneficiaries vs entire population

<table>
<thead>
<tr>
<th>Region</th>
<th>BReST beneficiaries (February 2018)</th>
<th>MICS 2018*</th>
</tr>
</thead>
<tbody>
<tr>
<td>NBR/Kerewan LGA</td>
<td>57.0%</td>
<td>34.4%</td>
</tr>
<tr>
<td>CRR</td>
<td>55.7%</td>
<td></td>
</tr>
<tr>
<td>Kuntaur LGA</td>
<td></td>
<td>19.5%</td>
</tr>
<tr>
<td>Janjanbureh LGA</td>
<td></td>
<td>18.5%</td>
</tr>
<tr>
<td>URR</td>
<td>52.4%</td>
<td></td>
</tr>
<tr>
<td>Basse LGA</td>
<td></td>
<td>16%</td>
</tr>
<tr>
<td>National rate</td>
<td></td>
<td>18.6%</td>
</tr>
</tbody>
</table>

Source: Project administrative data and MICS 2018

*MICS 2018 data were collected between January and April 2018.

28. During the collection of quantitative data for the purpose of this evaluation, all BReST children were more than 23 months old. That notwithstanding, the analysis allowed detecting the extent to which beneficiary mothers applied their knowledge in YCIF
practices to their younger children, and if the dietary outcomes were better compared to non-beneficiary mothers’ children. This could be viewed as a measure of sustainability, to test if good feeding practices continue beyond the end of the project. The data do not show any significant difference between children in the comparison group and those in the treatment group. Without the cash transfer, mothers could not probably keep up with good feeding practices, despite having acquired new knowledge. This confirms the findings from FGDs, during which beneficiaries reported lower expenses on food consumption and less food diversity since they stopped receiving the cash transfer. The most common consumption cuts are on animal protein such as eggs or fish.

29. The analysis of the results by the sex of the child attested to a significant difference between boys and girls in the comparison group (42% for boys and 13% for girls had a diet with the minimum diversity); the data available to the evaluation team did not have information on what would explain the gender difference in the comparison group. For BReST beneficiaries however, there is not significant difference in minimum food diversity between boys and girls.

30. **Minimum meal frequency** is presented by the percentage of children aged 6 to 23 months who received solid, semi-solid and soft foods the minimum number of times or more during the previous day. As for minimum dietary diversity, comparison was made between younger children of BReST mothers and their counterpart in the comparison group. The results are similar to those found for the minimum dietary diversity: the fact that the mother was a BReST beneficiary does not make any statistically significant difference to the younger (and non-BReST) child’s minimum meal frequency. The analysis was also done by sex of the child, and no significant difference between girls and boys was found.

31. **Minimum acceptable diet** combines the two previous indicators and assess the proportion of children between 6 and 23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day. Again, there is no significant difference between children whose mothers were BReST beneficiaries, and children from the comparison group. Figure 11 presents the proportion of children with an adequate diet. When analysing the proportion of children who receive a minimum acceptable diet, the evidence shows a significant difference between girls and boys in the comparison group. Boys tend to get minimum acceptable diet more often than girls (33% against 8%).

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7 Breastfeeding children: Solid, semi-solid, or soft foods, two times for infants age 6-8 months, and three times for children 9-23 months; Non-breastfeeding children: Solid, semi-solid, or soft foods, or milk feeds, four times for children age 6-23 months.
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

Figure 11: Proportion of children with a minimum dietary diversity, minimum meal frequency, and minimum acceptable diet

![Graph showing the proportion of children with different dietary factors](image)

Source: Project endline survey

WASH practices

32. Counselling in WASH is an important component of the project. The use of safe drinking water, washing hands at the right moment, and having good sanitation practices contribute to improved child health and nutrition status. During the focus group discussions with VDCs and VSGs, access to safe water was mentioned among the top priorities of the communities. This need for clean drinking water is supported by the quantitative survey findings: BReST beneficiaries tend to have less access to clean water, during both rainy and dry season, as compared to the comparison group (Figure 12). Yet, the beneficiaries are also those using less often adequate water treatment techniques when needed (Figure 13).

Figure 12. Access to clean drinking water during dry and rainy seasons

![Graph showing access to clean drinking water](image)

Source: Project endline survey

Figure 13. Proportion of women using adequate water treatment techniques when

![Graph showing proportion of women using water treatment techniques](image)
33. Concerning hygiene, specifically handwashing, the proportion of women who wash their hands at the critical moments is significantly higher among BReST beneficiaries. In fact, 70% of beneficiaries wash their hands at the critical moments against 51% in the comparison group (Figure 14). The data show that participation in the project, after controlling for women and geographical characteristics, increases the probability to wash the hands at the right moment by 21%.

Source: Project endline survey

Delivery assisted by skilled personnel

34. The BReST project had a significant effect on the number of deliveries performed in health facilities. The results from the respondent survey show that 93% of BReST beneficiaries gave birth in a health facility against 87% among non-beneficiaries (Figure 15). When controlling for women and geographical characteristics, the evidences show that participation in BReST increases the chances to give birth at the health facility by 6%.

Figure 15. Proportion of women who delivered in a health facility

Source: Project endline survey

35. Through FGDs, beneficiaries mentioned that the main determinant for delivering in health facilities instead of at home is the availability of transportation to the health facilities. Women who delivered at home are those who live far from health facilities with no readily available means of transport, or those whose labour went very quickly that there was no time to get to the health facility. Villages that has obtained a vehicle or “ambulance” in

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8 The use of household survey (with random selection of respondents) and not health facility data reduces the bias toward women who delivered in the HF. In case HF data were used, women who did not give birth in HF would have been missing from the analysis. This is not the case here.
the form of a car or a tricycle reported increased institutional delivery. These vehicles were funded by other projects including MCNHRP and the Department of Community Development. Overall, there is good understanding of the importance of institutional delivery, and all beneficiaries prefer it when possible.

36. When looking at the change in institutional delivery before BReST started (Q1-Q2 of 2016) and after (Q1-Q2 of 2019), BReST Health Facilities do show slightly higher increase compared to non-BReST Health Facilities (Figure 16). However, there is no evidence that this is due to women switching from home delivery to institutional delivery because of the BReST project. However, it is possible that some women chose to deliver in BReST facility instead of neighbouring Non-BReST facilities, for them to be able to register with the BReST project. The country overall experienced a high increase in institutional delivery, which is in line with The Gambia National Health Strategic Plan 2014-2020 to improve the coverage of skilled delivery including through shifting from the promotion of community births to institutional deliveries and encouraging early antenatal booking at health facilities.

![Figure 16. Institutional delivery increase between Q1-Q2 of 2016 and Q1-Q2 of 2019 in BReST HFs and Non-BReST HFs in NBR, CRR and URR](image)

- **Vitamin A supplementation and deworming**

37. Vitamin A supplementation and deworming are provided to children from 6 months for Vitamin A and one year for deworming, every 6 months. These two services are among the Government’s priorities. All BReST child beneficiaries who came and collected the cash transfer were given vitamin A supplement and deworming when appropriate. Vitamin A and deworming were only implemented in the BReST interventions after six months since they are only administered among children of 6 months and older. However,
during the implementation of the BReST project, Vitamin A and deworming screening was included in the payment day activities to ensure that all BReST child beneficiaries were receiving the two services in time. Those who were not up to date with their vitamin A and deworming services would receive it during the payment day. We could not, however, find in the evaluation survey any evidence of a significant and positive impact of BReST on the number of children receiving deworming and vitamin A, although, according to administrative data, all children of beneficiaries who had received the last payment had received deworming and Vitamin A. In the Gambia, about 18% of children under 5 are Vitamin A deficient according to the Gambia micronutrient survey 2018 (GMNS 2018). The rate is lower for children less than 24 months (4% for 6-11 months and 9% for 12-23 months). At the LGA level, Kuntaur (27%), Basse (27%) and Janjanbureh (33%) LGAs, areas covered by BReST, have the highest level of vitamin A deficiency, still according to the GMNS 2018.

EQ 2.2. To what extent has the project contributed to increasing beneficiary households’ resilience to income shocks?

38. Beneficiaries’ resilience can be affected by the project in the long term and short term. In the long term, improved health from better nutrition, access to health care, vaccination, Vitamin A, deworming and other health services has been globally acknowledged to increase children’s future productivity. The BReST project components of cash transfer, nutrition education and health services with clear impact on beneficiary children’s health, in turn, improves human resource capacity among beneficiaries and their long-term resilience.

39. In the short run, the project’s impact on household’s economic resilience can be assessed by whether it has helped women improve their household productive capacity or savings, which will reduce negative coping mechanism in times of economic shocks. Through FGDs with beneficiaries, beneficiaries’ spouses and VSGs, as well as KIIIs with social workers, the evaluation team found that the majority of women invested or saved some of the cash transfer they received. The most common type of investment of the BReST transfer was in small livestock such as goats or sheep, while a smaller number of women started petty trading such as selling peanuts, cooked snacks and other food. In all the areas visited, the majority of beneficiaries and beneficiaries’ spouses in the FGDs reported that their households obtained female goats or sheep. A young goat or sheep costs between 2,000 to 3,000 dalasi, and beneficiaries were able to afford them through a group saving system where several BReST beneficiaries in the village put together some of the benefit money and take turn in withdrawing the sum every month. Additionally, some women reported to open bank accounts to save the money for future needs. However, this is limited to a small number of women and only in villages with relative proximity to a bank.
40. Quantitative analysis confirms results from the FDGs and KIIs. About 38% of BReST women could save money in the past 24 months preceding the interview, against only 33% among non-beneficiary women (Figure 17). The results are more striking when it comes to the purchase of productive assets, in particular livestock: 56% of BReST beneficiaries declared having purchased a livestock during the past 24 months against only 23% among non-beneficiary women (Figure 18). Being a BReST beneficiary increases the probability to purchase livestock by about 47%.

41. According to beneficiaries, the main reason for investing the money is to secure their children’s future needs. During the evaluation, the majority of the ruminants bought through the cash transfer (and in some cases, the ruminants’ offspring) still existed and the small businesses initiated though the cash transfer were still running. However, it was too early to tell whether, and how long, the investment/savings would remain over time. It is likely that they will be used as coping mechanism when the next economic shock hits the family. In the absence of any additional regular income provided to them by BReST, beneficiaries may also become gradually used to cover consumption needs that were previously covered by the BReST monetary support. However, it is interesting to see that among women who invested the “BReST money” in the purchase of productive assets (livestock and garden -- both comparison and treatment groups), child food/nutrition outcomes are better for BReST beneficiaries (Table 7).

Table 7. Rates of minimum dietary diversity, minimum meal frequency and minimum acceptable diet when the mother invested in productive assets

<table>
<thead>
<tr>
<th></th>
<th>Treatment</th>
<th>Comparison</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum dietary diversity rate</td>
<td>100,0%</td>
<td>40,9%</td>
<td>45,8%</td>
</tr>
</tbody>
</table>
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

<table>
<thead>
<tr>
<th>Minimum meal frequency</th>
<th>66.7%</th>
<th>60.9%</th>
<th>62.1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum acceptable diet</td>
<td>50.0%</td>
<td>34.8%</td>
<td>37.0%</td>
</tr>
</tbody>
</table>

Source: Project end line survey

42. The project also contributed to increasing beneficiary women participation in income generating activities (IGA): 77% of BReST beneficiaries are active in an IGA against 64% in the comparison group (Figure 19). BReST beneficiaries are mainly involved in agriculture (cropping and livestock raising) and trading (Figure 20).

43. The BReST project made a significant impact on beneficiary children’s birth registration rate, and this can be considered as the project biggest unintended positive effect. Although this was initially not part of the project’s objectives, the BReST project facilitated the access of beneficiary children and mothers to birth certificate or other identity documents. Six months after implementation started, the BReST project included birth registration service as part of its activities.

44. With the help of the Ministry of Health, beneficiary children were able to be registered for birth certificate during the payment day. As a result, birth certificate ownership among BReST beneficiary children is on average 80.1%, a significantly higher rate if compared to the registration rate observed in the population of children under 5 in the Gambia, which was 47% according to MICS 2018 (Error! Reference source not found.). The highest
performing HF in terms of children’s birth certificate ownership is Ngayen Sanjal with 91%, followed by Dakunku and Albreda with 90%. The lowest level, although still considerably higher than the national average, was found in Basse (56%) and Essau (68%). Overall, beneficiaries show a good understanding of the importance of birth registration for their children. Beneficiaries mentioned that having it integrated in the BReST project really saved them time and cost for the process.

45. The project’s impact on ownership of identity documentation among beneficiary mothers is less clear. The project required women to have identity documents to be able to register, but it was rather flexible since ID card, birth certificate, voter’s card or alien card for non-citizens who are residing in Gambia, or attestation from the head of village, were accepted. The majority of beneficiary mothers reported that they had one of these documents prior to registering to BReST, while only a small number had to be supported by the project to obtain a birth certificate. During the end line survey, only 45% of BReST beneficiary mothers declared having a birth certificate. The proportion of birth certificate among non-beneficiary mothers was very similar (44%) and not statistically different, corroborating previous findings.

**PRELIMINARY CONCLUSIONS: IMPACT**

**IMP1.** The project displays positive effect on beneficiary children’s nutrition status, particularly during the lifetime of the project. This effect is most apparent in NBR-East and to a lesser extent in URR, while NBR-West and CRR did not show notable effects. In addition, the project’s administrative data indicated that the prevalence of GAM and SAM among BReST beneficiary children decreased throughout the project implementation period, which is seen to be an effect of the project in combination with other developments (overall decrease of acute malnutrition even in non-Brest areas) as well as age effect. In relation to this, minimum dietary diversity during the project was found to be significantly higher among BReST beneficiaries compared to the rest of the population [Par 17-22].

**IMP2.** However, these effects seem to fade as soon as the cash transfer stopped. A quantitative survey conducted in December 2019 showed no evidence of a significant effect of the BReST project on the prevalence of GAM and SAM, when comparing beneficiaries with non-beneficiaries. Similarly, although minimum dietary diversity during the project
was found to be significantly higher among BReST beneficiaries, post-project survey showed no significant difference between beneficiaries and non-beneficiaries in minimum dietary diversity and meal frequency [Par 23-24, 29-32].

IMP3. Evidences showed the significance of cash transfers in improving consumption. FGDs with beneficiaries, beneficiaries’ spouses as well as VSGs and VDCs revealed testimonies that the monetary support provided by BReST was essential in helping families purchase additional and more diversified food, but these families struggle to maintain their such consumption pattern once the cash transfer has stopped. Despite improved knowledge gained from the project, some positive practices have not been maintained beyond the lifetime of the project due to the absence of monetary support [Par 29].

IMP4. Improved knowledge among beneficiaries translates to higher rates of exclusive breastfeeding, skilled delivery and hand washing practices, but not to adequate water treatment techniques. The project’s objectives of improving exclusive breastfeeding and institutional delivery appear to have materialised as they are significantly higher among BReST beneficiaries compared to non-beneficiaries. Regarding hygiene practices, however, the evidence is less conclusive as beneficiaries show better hand washing practices but less adequate water treatment techniques [Par 25-36].

IMP5. The BReST project contributed to reducing gender differences in diet diversity and meal frequency. Evidences show that there was a significant difference between girls and boys in terms of minimum dietary diversity and minimum acceptable diet, but only in the comparison group. There is no difference among BReST beneficiaries [Par 30, 32].

IMP6. The BReST project shows positive effects on household’s economic resilience by improving household productive capacity or savings. The evaluation found that the majority of women invested or saved some of the cash transfer they received. The most common investment is in the form small livestock such as goats or sheep, while a smaller number of women started petty trading. A small number of women have also reported to open bank accounts to save the money [Par 39-43].

IMP7. Though not initially part of the objectives, the BReST project has a significant impact on birth certificate ownership among beneficiary children. At an average of 80.1%, beneficiary children’s birth certificate ownership is significantly higher compared to the population of children under 5 in the Gambia, which was 47% according to MICS 2018. Birth registration service was included in the BReST project activities six months after implementation started, and it can be considered the most significant unintended impact of the project [Par 44-45]
4.3 Effectiveness

**EQ 3.1.** To what extent did the BReST project achieve its expected results?

**EQ 3.2.** To what extent has the project contributed to behavioural change in nutrition and care practices in the targeted communities?

**EQ 3.3.** Were the project’s behavioural change and communication strategies appropriate to achieve the expected results?

**EQ 3.4.** What (if any) are the project unintended and unexpected results?

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Illustration 4. Behavioural Change flipchart used by BReST during the Health counselling sessions at the health facility (@UNICEF Gambia / 2019)
EQ 3.1. To what extent did the BReST project achieve its expected results?

**Project coverage**

46. The BReST project has reached its target in terms of coverage areas and has exceeded its initial target of the number of beneficiaries. The project initial target was 5,500 women in 10 Health Facility catchment areas (each HF was given a quota of beneficiaries). Through efficiency savings and in response to requests from the regions, the project was able to increase its effectiveness and to exceed the target and register a total 6,176 women. Each month, the number of women (or their procurator) turning up to health facilities and receiving the cash transfers ranged between 5,556 and 5,898 in the period of October 2017 to March 2019.

47. The project managed also optimised the use of funds to cover more beneficiaries and thus increased its effectiveness. There are undisbursed funds as some beneficiaries failed to attend the payment event and therefore did not receive their cash transfers in that particular month. Some women dropped out of the project because the baby passed away or the family moved out of the area. These remaining funds were then used to cover additional beneficiaries. Health facilities were able to request for additional quota of beneficiaries when national target was not filled and the PMT made decisions based on these requests.

**Capacity building of national stakeholders**

48. The project is considered effective in building capacities of government partners in implementing a social transfers project and collating evidence on the importance of such project. The BReST project was for the most part implemented by governmental institutions, primarily NaNA, DSW and MoH, with support from UNICEF. The overall implementation of the project at national, regional and health facility level ran smoothly with only minor hiccups. Technical problems, such as changes in the use of data collecting system, were resolved in timely manner without significant interference to the project schedule.

49. Staff at the different levels are knowledgeable about the project and very clear about the tasks given to them. On the ground, NaNA officers, health workers and social workers worked closely together to ensure payment days are organized effectively and beneficiaries are well informed and followed up when necessary.

50. Training sessions were offered to all relevant staff in the inception of the project and quarterly refresher training opportunities were made available to the key project implementing partners, both at national and regional level. All stakeholders interviewed expressed satisfaction with the content of their respective training and stated that the training included all the information they needed to perform their tasks in the project.
The only identified weakness was the frequency of such training sessions. Comprehensive trainings were only provided to all staff in the beginning, while there were no specific trainings provided to new staff joining the programme after inception. The regular quarterly meetings, which may be a good opportunity to train new staff, did not specifically target them. This is particularly a problem for health workers since there is a high turnover rate among them. Many people who later joined the project had to learn it on the job. The situation led to extra workload for the remaining staff, in addition to the already high workload, particularly during payment days. Stakeholders suggested that future projects should have continuous training mechanisms to ensure all staff members are covered.

51. KIIIs and FGDs conducted during this evaluation show that overall, stakeholders are satisfied and very proud of what the project has achieved. Implementing partners view the BReST project as one of the most successful social protection projects, both from the implementation side as well as the perceived impacts on beneficiaries’ lives.

52. Limitations were noted in terms of the number of social workers and facilities provided to them. The roles of social workers were considered essential in liaising with the beneficiaries and following up/resolving any problems that beneficiaries had in relation to the project. However, the number of social workers assigned to the project (1 primary social worker plus two assistants per region) was considered too small. The job requires them not only to be at the payment points, but also travel to communities whenever there were issues identified. To facilitate their activities, they are provided with one motorcycle and reimbursement of fuel. Given the vast area and number of beneficiaries they had to cover, stakeholders suggested that the resources needed to be improved. Unfortunately, this limitation is not specific to the BReST project. Gambia has a low number of social workers although their roles in various social programmes are very important. Stakeholders suggested that future similar projects employ more social workers and provide them with better facilities and remuneration. Future Social Protection initiatives should explicitly address the recruitment and training of the social workers at the start of the project.

Table 8. Achievement of project indicator

<table>
<thead>
<tr>
<th>Specific objectives &amp; Expected results</th>
<th>Achievements at the time of the evaluation</th>
<th>Level of achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO1: Improved nutritional status and caring practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicator 1: a 10% increase in individual dietary diversity score</td>
<td>Not measured in the project monitoring system</td>
<td>N/A</td>
</tr>
<tr>
<td>Indicator 2: an increase in the frequency of child meals</td>
<td>Could not be estimated due to lack of age-disaggregated data on in the monitoring system</td>
<td>N/A</td>
</tr>
</tbody>
</table>
**End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019**

<table>
<thead>
<tr>
<th>Indicator 3: an increase in the diversity of child meals</th>
<th>Over 50% children in the BReST programme received the minimum diversity of meals, against 18.6% in the population (par 26)</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 4: an increase of exclusive breastfeeding practice, reaching a total of 52% of them</td>
<td>91% of children in the BReST programme were exclusively breastfed, against 55.2% in the population (par 23)</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

**SO2: Improved implementation of related Government Policies through building capacities of government partners and civil society organisations.**

| Indicator: stakeholders have increased capacity and evidence on the effectiveness of social protection using conditional cash transfers. | Implementation by national stakeholders ran smoothly, project staff trained and highly knowledgeable on cash transfer and social protection (par 47-50) | Achieved |

**ER1: Income provided to mothers of children 0-24 months.**

| Indicator: 5,500 women receive cash transfers of 600 GMD/months for 24 months. | 6,176 women registered, between 5,556 and 5,898 received transfers each month (par 45-46) | Achieved |

**ER2: Enhanced knowledge and skills in mother, infant and young child feeding practices.**

| Indicator 1: number of mothers counselled for infant and young child feeding practices | 95.2% of BReST beneficiaries received counselling on IYFP, against 80.9% for the comparison group (par 56) | Achieved |
| Indicator 2: number of children receiving vitamin A supplementation and deworming in addition to the regular RHC programme. | Vit A and deworming services are part of the government regular RHC and BReST only caters for children who missed out on these services. However, the indicator implies that BReST should improve Vit. A and deworming service coverage among beneficiaries. The end line survey found no evidence of a significant difference in the numbers of children dewormed and receiving Vit A between beneficiaries and non-beneficiaries (par 37). BReST performed its task of ensuring beneficiaries are compliant with vitamin A and deworming take-up, bit did not result in higher coverage among beneficiaries. | Partially achieved |

**ER3: Increased attendance at growth monitoring sessions.**

| Indicator: the number of women attending a mother and infant welfare session. | All beneficiaries receiving cash transfer attended mother and infant welfare session, and absenteeism is very low (Figure 23) | Achieved |

**ER4: Evidence based advocacy and capacity building for introducing and expanding cash transfer projects.**

| Indicator1: number of advocacy workshops conducted | Advocacy activities include: Quarterly workshop with project implementation and governance structures; Regional Consultative and Capacity Building Workshop conducted annually in 2017, 2018 and 2019; Annual Project Review Workshop conducted for the first time in 2018 | Achieved |
**EQ 3.2. To what extent has the project contributed to behavioural change in nutrition and care practices in the targeted communities?**

53. As demonstrated in the previous section regarding project impact, the BReST project has a significant effect on beneficiaries’ behaviours with regards to exclusive breastfeeding, child feeding practices, hygiene/hand washing practices and delivery in health facilities. Project stakeholders, particularly the nutrition field officers, public health officers and community health nurses, attribute a big part of this achievement to the nutrition education provided by the BReST project to the mothers.

54. According to informants, one of the greater changes was the higher uptake of the exclusive breastfeeding practice among BReST beneficiaries. It is acknowledged that the influence of the BReST project in the behavioural changes in nutrition and care practices cannot be completely isolated, since there are other projects in the communities including the World Bank’s MCHNRP and WFP’s food supplementation project. However, the impact the BReST project has been better demonstrated by quantitative analysis comparing the performance of BReST beneficiaries with that of the rest of the population in the same region, who are all benefiting from the other projects. This positive result is reasonable, since breastfeeding practices is one of the priorities in the BReST project, which specifically target breastfeeding women, more so that other projects.

55. On the other hand, despite improved knowledge gained from the project, some positive practices have not been maintained beyond the lifetime of the project. These, in particular, are practices that heavily relied on the cash assistance such as the minimum acceptable diet, which in turn affects acute malnutrition level.

*In the past, many mothers did not give the colostrum to their babies. They believed that colostrum is not milk since it does not look like milk, so it is not good for the baby and has to be thrown away. Through the nutrition education sessions in the BReST project, they learned that colostrum is the best first food for the baby and the baby should not be given anything else but breast milk until the baby is 6 months old.* – Individual interview, key informant, Essau
EQ 3.3. Were the project’s behavioural change and communication strategies appropriate to achieve the expected results?

56. The nutrition education was provided to the mothers face-to-face on the payment site. Narrative explanations were accompanied by pictures to illustrate the topic. The subject changes in line with the expected age of the children e.g. 0-6 month of implementation covers topics of exclusive breastfeeding, then followed by supplementary feeding, hygiene etc. This method is considered effective by stakeholders and beneficiaries. This strategy ensures that all beneficiaries who come to collect the payment receive the message and beneficiaries can ask questions related to the subject of the specific month. Beneficiaries are generally receptive of the messages. Social workers and health workers used the community radio twice a month to deliver the SBCC component.

57. Counselling is an important component of the project. In general, a high proportion of women, both beneficiaries and non-beneficiaries, received some type of counselling (87.9%), as shown in Table 9. Except for counselling in regular growth monitoring, a significantly higher proportion of BReST beneficiaries received counselling in the different themes, as compared to non-beneficiaries. Almost all BReST beneficiaries (95.2%) received at some point counselling on some IYFP, against 80.9% for the comparison group. More than 90% of BReST beneficiaries received counselling in exclusive breastfeeding and WASH against around 75% for non-beneficiaries. This resulted, as previously described, in
a particularly positive impact of the project on exclusive breastfeeding and hygiene. Regular growth monitoring and family planning are the two subjects with the least proportion of counselling received. Indeed, it was mentioned during some of the KII in health facilities, that the project may have had a negative impact on the use of contraceptives, as some women, willing to participate to the BReST project, stopped the use of family planning in order to get pregnant. Counselling in family planning should have therefore been intensified, as pregnancies are a perceived possible side effect of the project.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Treatment</th>
<th>Comparison</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any IYFP</td>
<td>95,2%</td>
<td>80,9%</td>
<td>87,9%</td>
</tr>
<tr>
<td>Exclusive breastfeeding</td>
<td>94,7%</td>
<td>77,3%</td>
<td>85,8%</td>
</tr>
<tr>
<td>WASH</td>
<td>92,0%</td>
<td>73,7%</td>
<td>82,7%</td>
</tr>
<tr>
<td>Timely and appropriate complementary feeding</td>
<td>77,5%</td>
<td>64,4%</td>
<td>70,9%</td>
</tr>
<tr>
<td>Importance of vaccination</td>
<td>67,9%</td>
<td>63,9%</td>
<td>65,9%</td>
</tr>
<tr>
<td>Regular Growth monitoring</td>
<td>38,0%</td>
<td>50,5%</td>
<td>44,4%</td>
</tr>
<tr>
<td>Family Planning</td>
<td>51,9%</td>
<td>45,9%</td>
<td>48,8%</td>
</tr>
</tbody>
</table>

Source: Project end line survey

58. Counselling was provided mainly at health facilities (Figure 21); 90% of women declared having received at least one counselling session in the health facility (99.5% among BReST beneficiaries). The radio is also a common way of sending messages. More than one third of women (38%) received counselling through the radio. However, this last channel is more frequent among non-BReST beneficiaries: almost 50% of non-BReST beneficiaries received some kind of counselling though radio, against only 26% among BReST beneficiaries. Radio can be a powerful channel to reach household in a large scale, as almost 70% of Gambian households hold a radio according to the MICS 2018.
59. Weaknesses of the nutrition education component, as pinpointed by stakeholders and beneficiaries, did not relate to the topics discussed but rather to the number of sessions participants and the limited capacity of the health centres. In some health centres, due to the large number of beneficiaries, they had to queue to wait for their turn without sufficient seating facility.

**EQ 3.4. What (if any) are the project unintended and unexpected results?**

60. As previously mentioned, increased possession of birth certificate among beneficiary babies is seen as the project’s most significant unintended effect. Birth registration improvement was not part of the original objectives of the project. However, as the project started running, stakeholders saw the opportunity to include birth certificate services as part of the project’s activities. This provided beneficiaries with a lot of ease in registering the birth of the babies and going through procedures to obtain birth certificates. Birth certificate ownership among BReST beneficiary children is on average 80.1%, significantly higher compared to birth certificate ownership for the population of children under 5 in the Gambia, which was 47% according to MICS 2018.

61. The project also provided assistance to beneficiary women to obtain birth certificate in case they do not possess any official identification documents required to become beneficiaries. However, qualitative as well as quantitative data collection did not find this effect to be strong, as many women had already owned one of the identity documents required (ID card, birth certificate, voter’s card or alien card for non-citizens who are residing in Gambia).

62. Among the other BReST unexpected effects is the higher promotion of gender equality within the household thanks to the enhanced dialogue on money matters between the
female beneficiaries and their husbands, as detailed in section 6.3 on gender. The improvement of relationships between communities and social and health workers was also reported as a positive unforeseen effect.

**PRELIMINARY CONCLUSIONS: EFFECTIVENESS**

**EFFECT 1.** The BReST project has reached its target in terms of health facilities covered and exceeded its target in terms of beneficiaries. The initial project target to reach was 5,500 women in 10 Health Facility catchment areas. Through efficiency savings, the project signed up a total 6,176 women in 10 Health Facility catchment areas. Between 5,556 and 5,898 women received the cash transfers each month [Par 47, 48].

**EFFECT 2.** The project is considered effective in building capacities of government partners in implementing a social transfers project and collating evidence on the importance of such project. The BReST project was for the most part implemented by national institutions including NaNA, DSW and MoH, with coordination from UNICEF. Overall, staff are knowledgeable about the project and their respective responsibilities and implementation at national, regional and health facility level ran smoothly [Par 49, 50, 52].

**EFFECT 3.** Training opportunities were provided to project staff at different levels and the contents were satisfactory. During the inception of the project, training sessions were offered to project staff at national, regional and health facility levels. Through KII, staff stated that the training received provided them with the information they needed to perform their tasks [Par 51].

**EFFECT 4.** However, these training activities were only conducted once during the inception phase and did not include staff of payment institution. Following the inception phase there were no refresher training opportunities, even though new staff continuously joined the project. This is particularly a problem for health workers, whose turnover rate is particularly high. New staff had to learn on the job, leading to extra workload for the remaining staff [Par 51].

**EFFECT 5.** The BReST project has a significant effect on beneficiaries’ behaviour with regards to exclusive breastfeeding, child feeding practices, hygiene/hand washing practices and delivery in health facilities. Project stakeholders attribute a big part of this achievement to the nutrition education provided by the BReST project to the mothers. However, it was noted that some positive practices have not been maintained after the completion of the project due to the lack of monetary support [Par 54-56].

**EFFECT 6.** The nutrition education was in general considered effective by stakeholders and beneficiaries. The sessions were conducted face-to-face on the payment site,
ensuring all beneficiaries who come to collect the payment receive the message. The verbal communication was easily understandable and accompanied with descriptive illustrations [Par 57-59].

**EFFECT 7.** The most significant unintended effects of the project is the increased possession of birth certificate among beneficiary babies and increased gender equality within the household regarding household finance management [Par 61-63].
4.4 Efficiency

EQ 4.1. To what extent were financial resources in the BReST project adequate and used efficiently?

EQ 4.2. What could have been done to attain the same BReST project objectives but at a lesser cost?

EQ 4.3. To what extent were the payment operations properly handled?

EQ 4.4. To what extent were human resources in the BReST project adequate and used efficiently?

Illustration 6. BReST Beneficiaries’ lists used to check identities and validate payments, Demban Kunda Koto, Upper River Region (@UNICEF Gambia /2019)
EQ 4.1. To what extent were financial resources in the BReST project adequate and used efficiently?

63. The monthly cash transfer provided to the beneficiaries amounts to GMD 600, or GMD 14,400 per beneficiary over the 24-months project period. This amount was roughly 25 per cent of Gambia’s per capita monthly expenditure. The amount was calculated by utilizing the data from the Integrated Household Survey of 2010 and then inflating the monthly per capita expenditure to 2017. This calculation was made in line with recent research on the ideal level of cash transfer benefit amounts, ensuring that the desired outcomes and impacts are achieved. An evaluation of cash transfer projects across Sub-Saharan Africa (SSA) indicated the crucial threshold to be around 20 per cent of the share of consumption (Davis & Handa, 2015). Based on this standard, the adequacy of the cash transfer for beneficiaries is achieved.

64. The general beneficiaries’ perception was that the amount provided to them was significant in helping households improve their children’s care and nutrition as well as increase their savings. However, in places where beneficiaries are spread out in a large catchment area, particularly Basse, the benefit can be effectively reduced by 25% due to high transport costs. For future projects, stakeholders suggested that distance to payment sites should be considered when calculating benefits, or to split the catchment area into several points to ensure reasonable distance to all beneficiaries. It was also observed that the infrastructure in these sites was poorer than elsewhere.

65. The BReST project had a total budget of 3 million euro. The financial reports were accessible for actual spending and commitments until 31 July 2018, forecast expenditure between 1 August 2018 and 31 July 2019, plus expected expenditure on transfers during the extension period of 1 August 2019 to 31 October 2019. Over the length of the cash transfer period between April 2017 and October 2019, the total amount of cash paid to beneficiaries was 1.480.639 €, or nearly 50% of the total budget of the project. Other input costs include supplies, commodity and materials and grants to counterparts (NaNA and payment institution) as well as staff & personnel cost, contractual services, travel costs and general operating costs.

66. Looking at actual expenditure and commitments up to 31 July 2018, Transfers and Grants to Counterparts makes up 67.6% of the total cost, supplies commodity and materials makes up 3.6% of total costs, while staff and personnel, contractual services, travels and general operating costs constitute 12%, 8%, 1.7% and 0.6% of the total costs respectively. Administrative costs incurred by UNICEF is 6.5% of the total cost. This composition shows

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9 For beneficiaries with twins, triplets and quadruplets, the benefit amount increases with 50 per cent for each additional new-born. Hence, beneficiaries with twins receive GMD 900, equaling a total of GMD 21,600 over the 24-months project period.
a cost-efficient operation. Table 10 presents the BReST financial expenditure based on draft Interim Progress Report for the period 1st August 2017 – 31st July 2018.

67. Since the final financial report was not available to the evaluation, it was not possible to make an analysis of the project’s budget absorption.

Table 10. Financial expenditure based on BReST Interim Progress Report for the period 1st August 2017 – 31st July 2018

<table>
<thead>
<tr>
<th>BUDGET</th>
<th>Total Project Budget</th>
<th>Actual Expenditure as at 31st July 2018</th>
<th>Commitments as at 31st July 2018</th>
<th>Actual Expenditure and commitments) as at 31st July 2018</th>
<th>Forecast Expenditure (1st August 2018 – 31st July 2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff &amp; Personnel Cost (UNICEF)</td>
<td>277,806</td>
<td>202,806.41</td>
<td>0</td>
<td>202,806.41</td>
<td>54,000</td>
</tr>
<tr>
<td>2. Supplies, Commodities and Materials (UNICEF)</td>
<td>73,848</td>
<td>57,381.40</td>
<td>3,680</td>
<td>61,061.40</td>
<td>12,000</td>
</tr>
<tr>
<td>3. Contractual Services (UNICEF)</td>
<td>185,553</td>
<td>114,414.57</td>
<td>21,138.12</td>
<td>135,552.69</td>
<td>50,000</td>
</tr>
<tr>
<td>4. Travel** (UNICEF)</td>
<td>64,000</td>
<td>28,589.50</td>
<td>0</td>
<td>28,589.50</td>
<td>20,000</td>
</tr>
<tr>
<td>5. Transfers and Grants to Counterparts (NaNA and Payment Institution*)</td>
<td>2,040,364</td>
<td>1,142,888.40</td>
<td>0</td>
<td>1,142,888.40</td>
<td>800,000</td>
</tr>
<tr>
<td>6. General operating and another direct costs*** (UNICEF and NaNA)</td>
<td>37,000.00</td>
<td>9,620.88</td>
<td>0</td>
<td>9,620.88</td>
<td>15,000</td>
</tr>
<tr>
<td>7. Total direct eligible costs of the Action (1-6)</td>
<td>2,678,571</td>
<td>1,555,701.16</td>
<td>24,818.12</td>
<td>1,580,519.27</td>
<td>951,000</td>
</tr>
<tr>
<td>8. Administrative costs (maximum 7% of 7, total direct eligible costs of the Action) (UNICEF)</td>
<td>187,500</td>
<td></td>
<td>109,962.89</td>
<td>66,570</td>
<td></td>
</tr>
<tr>
<td>9. Contingency</td>
<td>133,929</td>
<td></td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>10. Total eligible costs of the Action (8+9)</td>
<td>3,000,000</td>
<td>1,690,482.16</td>
<td>1,017,570</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EQ 4.2. What could have been done to attain the same BReST project objectives but at a lesser cost?

68. When exploring what could have been done to attain the same BReST project objectives but at a lesser cost, the only possible reduction is cost is if the money could have been transferred to beneficiaries electronically. The manual payment system requires higher transaction cost to transport the money, staff and security personnel, among other things. However, given the lack of infrastructure and low literacy among beneficiaries, manual payment was the only viable option. At the same time, the manual transfer comes with face-to-face interaction that facilitates other components of the project such as nutrition education and child health screening.

69. The evaluation also noted that the project improved cost efficiency through its flexibility to increase the number of beneficiaries and move beneficiary quota from areas with lower demand to areas with higher demand. This way, the project as able to optimise the amount distributed to beneficiaries.

70. From the side of the beneficiaries, their transaction cost could have been minimised by reducing the distance and time spent on the payment day. Transport costs of up to 150 dalasi (i.e. ¼ of the benefit) and at least half a day of time spent during the payment day (which could have been used to do household chores or income generating activities) could reduce the project’s impact considerably.

EQ. 4.3. To what extent were the payment operations properly handled?

71. Based on the analysis of the financial reports and interviews with stakeholders, the evaluators note that the payment system put in place for BReST proved very efficient throughout the full implementation of the project. Efficiency can be explained by a combination of factors including:

a) Know-how on cash transfer distribution practices

72. Payment were processed and monitored by a local NGO whose knowledge of the field greatly contributed to the operational efficiency of the operations. Indeed, previous experiences with other United Nations agencies delivering social transfers enabled to operate fluidly and with a good knowledge of the local populations. In addition, the payment system was set up in a coordinated manner with the main partners. The project proceeded in stages as the instruments were progressively put in place: a voucher system enabled the first payments and in a second phase, following the issuance of the cards, the

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10 Mobile and electronic transfers, given sufficient infrastructure, are associated with lower costs for both programme implementers and recipients (see e.g. Fuel et al., 2018; Aker et al., 2013; Smith et al., 2011).
process was significantly facilitated, and properly secured with the verification of identities.

b) Securing the transfer of funds
73. To guarantee the transport of funds, the payment institution established a series of security procedures, predominantly among which, prohibition to travel with funds. As such, withdrawal of funds at the local bank would be done the same day of the payment. In addition, the transportation of cash was escorted to the payment site by the local police officers. These protective measures were facilitated by the local government and show synergies between the partners for the smooth running of the payment process.

c) A well-established process to verify identities, ensure the payment process and monitor the transactions
74. The evaluation team noted a good interaction between the payment provider and the social workers. Indeed, in order to circumvent the problems of initial verification (due to the progressive establishment of cards and the designation of prosecutors, among others), the NGO and the social workers proceeded to crosscheck the data from their lists in order to confirm the identity of the beneficiaries attending the venue. The presence of the Social Worker enables a second verification and record process. Before leaving the venue, the service providers ensure that all the reconciliation processes are done. Once the payment is completed, the NGO holds a debriefing session with the social workers to comment on the incidents and perform the reconciliation. The debriefing session includes an assessment of the complaints received during the day in order to reduce the sources of misunderstanding/ miscommunication, fraud.

“When we arrive at the venue, we have our desk, where you do the confirmation on identity. We are two staff. One staff will be checking your records to ensure you are the very person. If you don’t do that, somebody may come, and you may mistake you for another person, especially at the beginning when the cards were not very clear, you cannot ensure the payment is done to the right person. After the verification, we move to the second part, that is the payment, and we stamp all lists.”
Interview with Stakeholders at the Regional Level, Basse

“We confront their list with our list then we provide statistics with the information. We confirm how many people have been paid, how many people have been absent how many of them have transferred, how many children passed away... all the basic statistics are done”.
Interview with Stakeholder at the National Level
d) An accurate complaint mechanism

75. Following the testimony of beneficiaries and service providers, the evaluation team found that the complaints desk set up during payment days has been effective in delivering information to the populations and also in making the payment process easier. Initially used to verify identities, the complaint desk turned into an entry point to advice the beneficiaries. The complaint desk proved instrumental in the whole process, since it reduced overcrowding and allowed the agent to concentrate exclusively on the payment desk.

“There is a process of learning and understanding from the beneficiaries such that if there is a complaint the first time, they will learn why they have been rejected and next time they will change what needs to be changed. There is a learning progress that takes place through the payment process.”

Interview with Payments Service Provider

76. During the visits to the health facilities and during the interviews with the social workers, the evaluators did not find the presence of a complaint book. However, the beneficiaries do report that their complaints have been noted and that the staff present during the payment days has provided accurate information and explanations.

“When a second payment day was introduced in Basse, some beneficiaries will come the two days. When the service provider realized it, they would send the beneficiary to the complaint desk.”

Interview with Payments Service Provider

e) Strategies to minimize absenteeism

77. Absenteeism rates reported for the project during the whole period of implementation are low as shown in the figure below. The reasons given for absences relate mainly to travel costs, the length of payment days, forgetfulness or domestic constraints. However, the team of evaluators identified various measures -- established at the PMT level and relayed at the local level by social workers -- which effectively helped to counter absenteeism:

- Regarding the catchment area of Basse, the duplication of payment days had the effect of reducing the queues and wait time at the health facility. In addition, the evaluators note that the social workers jointly with the NGO responsible for payments facilitated the change of site (from one catchment area to another in the same region) for certain beneficiaries who are subject to frequent travel.
A communication strategy was put in place to notify, on payment days, dates for the next payments in order to avoid absences due to oversights. These notifications were then relayed locally by the communities and the radio.

**Figure 23. Absenteism during BReST implementation**

To minimize absenteeism, one thing we did is that, for every round of payment the PMT would have agreed on the next cycle of payment before the payment is done in each region... So that during the payment day it is announced when is the next payment... Because there you get almost everybody before they leave as part of the modules that we deliver to them, in addition to the radio programmes, we would announce the next visit, the day and the date so that they are aware.

Interview with Payments Service Provider

**EQ 4.4. To what extent were human resources in the BReST project adequate and used efficiently?**

78. The combination of human resources from UNICEF, NaNA, NACCUG, DSW and Health Facilities provided the project with the necessary set of expertise to run the project smoothly. As the main institutional partner, NaNA had previous experience in implementing the MNCHRHP project and was, therefore, able to lead the BReST implementation without a significant issue. As part of the MNCHRHP implementation, NaNA received funds from the World Bank intended to build capacity and hire experts and consultants. These human resources then continued with NaNA for the implementation of the BReST project. This high capacity was reflected by the high score
achieved by NaNA when undergoing the HACT (Harmonised Approach to Cash Transfer) micro assessment before the implementation of the project.

79. At the health facility and community level, the combination of, and coordination between health facility staff, community health workers and social workers not only ensured smooth processes for the cash transfer and nutrition education, but also maintain communication and follow-up with beneficiaries to optimise the effects of the project. Beneficiaries are overall satisfied by the professionalism of the project staff they encountered.

80. Social workers, in particular, had shown very high dedication given their limited number and the limited facility provided to them. In each of the three regions, the BReST project employed one full-time social workers plus two part-time assistants. The three persons attend payment days, provide follow-up services to beneficiaries who were absent or reporting any issues (including domestic conflicts) including by visiting the beneficiary households. This was done while covering multiple health facility catchment areas and provided with only one motorcycle. The limitation was particularly felt in North Bank Region, due to the size of the area. In this case the social workers managed to perform their work by closely coordinating with community health nurses to help communicate with beneficiaries that they could not reach. This situation is not specific to the BReST project but reflect the working condition of social workers in the Gambia in general. The country has a very low ratio of social workers while they have very important role in working directly with communities in grassroot level. Given the importance of their role, the Gambia needs to pay more attention to increasing the number and capacity of social workers.

81. All project staff received training in the beginning of the project and felt that they were provided with all the necessary information about the project and their respective roles. However, there were no refresher trainings so staff who joint the project after the start implementation did not receive training and had to learn on the job.

PRELIMINARY CONCLUSIONS: EFFICIENCY

EFFICIENCY 1. The cash transfer of GMD 600 per month is meaningful in helping the households improve care and nutrition of the children. The cash transfer represents roughly 25% of per capita expenditure, which, based on international experience, is sufficient to make an impact [Par 64,65].

EFFICIENCY 2. However, in places where beneficiaries are spread out in a large catchment area, the benefit can be effectively reduced by 25% due to high transport costs. For future projects, stakeholders suggested that distance to payment sites should be considered when calculating benefits, or catchment area could be divided into several points to ensure reasonable distance for all beneficiaries [Par 65].
EFFICIENCY 3. 50% of the cost expenditures are disbursed directly to beneficiaries as cash transfer, [Par 66, 67].

EFFICIENCY 4. The manual cash payment system is relatively expensive compared to electronic money transfers, but the latter was not a viable option given the lack of infrastructure and low literacy among beneficiaries [Par 69].

EFFICIENCY 5. The payment system put in place for BReST proved very efficient throughout the implementation of the project. Efficiency can be explained by a combination of factors including: (a) Know-how on cash transfer distribution practices, (b) Securing the transfer of funds, (c) A well-established process to verify identities, ensure the payment process and monitor the transactions, (d) an accurate complaint mechanism; and (e) Strategies to minimize absenteeism [Par 72-78].

EFFICIENCY 6. The combination of human resources from UNICEF, NaNA, NACCUG, DSW and Health Facilities provided the project with the necessary set of expertise to run the project efficiently. At the health facility and community level, the coordination between health facility staff, community health workers and social workers not only ensured smooth processes for the cash transfer and nutrition education, but also maintain communication and follow-up with beneficiaries to optimise the effects of the project [Par 79-80].

EFFICIENCY 7. The role of social workers is crucial, but their number is limited as well as the equipment provided to them. Unfortunately, this situation is not specific to the BReST project but reflects the working conditions of social workers in the Gambia in general. The country has a very low ratio of social workers while they have very important role in working directly with communities at grassroot level [Par 81].
4.5 Sustainability

EQ 5.1. To what extent did the project identify and build an existing national and local civil society and government capacities, structure and mechanisms to avoid dependency on UNICEF funds overtime?

EQ 5.2. To what extent were the project achievements sustained and for the most recent ones how will they be sustained when external support ends?

EQ 5.3. What has been done and what can stakeholders do more to ensure that project achievements are kept and improved further over time?

Illustration 7. WhatsApp Network created by Social Workers and NaNA staff to share information on the BReST project and other social and health related matters (@UNICEF Gambia/2019)
EQ 5.1. To what extent did the project identify and build an existing national and local civil society and government capacities, structure and mechanisms to avoid dependency on UNICEF funds overtime?

82. All the stakeholders interviewed stated that not only is there interest in the continuation of the project, but also the resources needed to implement the continuation of the project as part of the ongoing institutional reorganization. The general idea stated during the interviews at the National and local level is that "structures are now in place" and it would be unfortunate not to take advantage of the experience to scale-up the project. Indeed, beyond the structure at NaNA level, close collaboration between social workers, NACCUG and health personnel has been established and could be further cultivated by other interventions. All local agents met during the evaluation process are proud of the work carried out and are eager to contribute to further social interventions. For many of them, BReST provided an adequate framework for their professional and personal development.

83. At the level of the implementing agency, the skills built developed the PMT within NaNA but also at the health facilities constitute the core for a replication of the project. This construction was acquired through experience by adapting the organizational model to the needs of the project.

84. During interviews with local administrations, it was noted that the implication in the project design and implementation was limited. They were informed and invited to project’s events but were not actively involved in the actual implementation. The local administration plays an important role in terms of coordination, supervision and advocacy in their respective regions. A more active implication of local administrations has the potential to improve sustainability, as they can advocate for more funds for projects to the central government. Their role as coordinators and supervisors also has the potential to create and improve synergies between projects.

EQ 5.2. To what extent were the project achievements sustained and for the most recent ones how will they be sustained when external support ends?

85. Community-level focus groups reported improvements in household practices for breastfeeding, nutrition, WASH and infant care. These improvements concern not only the recipient women, but also other women not enrolled in the project. As the impact section shows, 93% of women who benefited from BReST applied exclusive breastfeeding and as many gave birth in health establishments. Hand washing at critical times is also a widespread practice (70% of BReST beneficiaries do it). This knowledge has been disseminated more widely within communities and allowed to reach other populations. However, as results in the impact analysis also show, despite a significant effect of BReST
on feeding and nutrition indicators during the project lifetime (when women were receiving the cash), the effect of the project faded out when the cash transfer stopped. Knowledge stayed, but practices that needed additional cash (e.g. food diversification) tend to decrease.

86. Also, evaluators have often heard from community birth companions that the incentive to deliver at the health facility was now understood by the majority of women. There are, however, cases that remain problematic. For the most remote villages of health facilities, joining the health center remains a problem, reflected in some financial arbitrations (traveling by motorbike can cost up to GMD 150) or in terms of safety (in rainy weather, travelling can sometimes become very difficult). In relation to these issues, the evaluators found that some communities had collectively decided to purchase tricycle ambulances to address mobility issues.

Illustration 8. Tricycle ambulance purchased with community funds, Basse, Upper River Region

87. The roles instituted by MCHNRP and BRéST at the level of support for the community seem to be sustainable. The knowledge gained during the implementation of BRéST is expected to continue for new pregnancies.

EQ 5.3. What has been done and what can stakeholders do more to ensure that project achievements are kept and improved further over time?

88. All the implementing partners consider that the training provided at the beginning of the project by UNICEF was sufficient and is now considered an asset. However, many agents engaged at the beginning of the project are no longer there, due in particular to high
attrition rates, which means ultimately a loss of human capital. Also, some key stakeholders like the NGO in charge of the payments were not included in the preliminary capacity building phase. Beyond these cases, capacity gained during the project implementation is acknowledged, and seems to have been potentialized by spontaneous collaboration. Through the dialogues with implementing partners, the evaluators noted the efforts made by NaNA at the national and regional levels in collaboration with social workers to strengthen dialogue and learning. An example of this is the creation of a dialogue space (on the WhatsApp network) to share information and to make monitoring and case referencing more visible. Another example concerns the documentation of problematic cases by social workers in their regular reports.

89. During the interviews, the evaluators noted that the interviewees advocate for maintaining or making use of the structure implemented within NaNA within the framework of the upcoming secretariat for social protection, under the responsibility of the vice-presidency. At this stage, however, the evaluators did not gather a clear suggestion of how the competences acquired during BReST implementation could be incorporated into the new structure.

PRELIMINARY CONCLUSIONS: SUSTAINABILITY

**SUS 1. BReST has put in place a sustainable organization and capacity.** There is a common agreement that the experience of BReST helped establish an organization around the implementing partner while building core programmatic skills. The “legacy” of BReST constitutes an opportunity for a replication of the project in view of the upcoming National Social Protection Strategy [Par 82, 83, 89].

**SUS 2. BReST promoted ownership and spontaneous collaboration between actors at different levels, especially at regional level.** The core training is considered an asset. But the fact remains that **local administrations should be more mobilized to further increase the sustainability of the project** [Par 84, 88].

**SUS 3. The achievements of the project are maintained, but with certain limitations.** If the practices and the organization implemented by the project seem sustainable, and therefore show a positive appropriation at the local level, economic factors can jeopardize these achievements. For example, high transportation costs hinder regular use of health services by the beneficiary women and children [Par 86, 87].

**SUS 4. The training provided at the launch of the project by UNICEF was sufficient to start the project, but due to high staff turn-over many of the persons originally trained have already left. Some other actors such as the payment services providers may have also benefitted from the training.** [Par 88].
4.6 Gender, Equity and Human rights

E.Q. 6.1. To what extent were Gender, Human Rights and Equity principles duly integrated in the design, delivery and monitoring of the project?

E.Q. 6.2. To what extent did the BReST project tackle the barriers that prevent girls' and women's access to the services that it made available in the targeted communities?

E.Q. 6.3. What unexpected effects, positive or negative can they be seen in relation to the issue of gender equality?

Illustration 9. Mother and child benefitting from the cash transfer program (@UNICEF Gambia / 2019)
E.Q. 6.1. To what extent were Gender, Human Rights and Equity principles duly integrated in the design, delivery and monitoring of the project?

90. The vision promoted by BReST is based on the rights of women and children. Its categorical targeting in the most vulnerable regions makes it possible to experiment with intervention mechanisms at key stages in the life cycle of children and women. Clearly, the specific targeting of women in the BReST design constitutes a first step towards a gender mainstreaming approach. The focus on the reproductive health of women in the last phase of gestation and during the 1000 days following childbirth allows for a suitable support during key stages of the lifecycle for mothers and children.

91. The specific targeting of women is however not sufficient to fully integrate a gender perspective. As mentioned in previous evaluations (EU, ROM, 2018), the evaluation team notes that the BReST project does not sufficiently target men, and therefore their essential role in care and support practices for children’s health. In doing so, the project goes along with the patriarchal culture, according to which health and education of children are women’s responsibilities. That notwithstanding, during the project implementation, a voluntary participation of men was observed in many of the activities intended for women (e.g., health talks, cooking lessons, hygiene). Also, messages disseminated via community radios allowed to reach out men.

E.Q. 6.2. To what extent did the BReST project tackle the barriers that prevent girls' and women's access to the services that it made available in the targeted communities?

92. Mothers met during the focus groups are very satisfied with the lessons and messages delivered by BReST in terms of nutrition and health practices. Both beneficiaries and their relatives state that the general well-being of the families and children supported for by BReST has improved considerably, thanks to the combination of the benefit and health and nutrition guidance. In line with the findings highlighted in the previous sections, the evaluation team confirms that the project effectively addressed barriers to access to health services and contributed to combating the unequal access to reproductive health services.

93. Furthermore, women declared that the transfers received enabled them not only to support income and consumption for their families but also to gain wider empowerment benefits, as recipients were able to choose and prioritize their own expenditure. In fact, the beneficiaries perceive non-conditionality as a pledge of security and flexibility as they can first ensure the priority expenditures and arbitrate on the use of the remaining amount. As described further below, the evaluation team noted that the project has provided a unique entry point for a dialogue between the female beneficiaries and their partners on the use of money. This ended up contributing to more equity on decision power and, therefore, to a balance of gender relations within the household.
94. BReST undoubtedly had a positive effect on the economic empowerment of women, enabling them to increase the capacity for income generation and investment through the use of part of the transfer for productive purposes. In the three regions, the evaluators widely listed the acquisition of small ruminants (goats and sheep) for savings in kind. Likewise, the evaluators found that informal credit and saving groups were widely practiced by women in the three regions, particularly to cover the purchase of ruminants. Locally, purchase prices vary around GMD 2000, which implies the need to collect the amounts through ROSCAS. Beyond these practices, it is interesting to note that for many women, BReST has made it possible to manage money regularly and independently.

95. In terms of decision-making power at the community level, the evaluation team did not notice any improvement. Admittedly, the project did not specifically aim for positive changes in this specific area, but interactions with local communities could have made it possible to encourage greater opportunities for women to debate on local affairs of their communities’ decision-making.

E.Q. 6.3. What unexpected effects, positive or negative can they be seen in relation to the issue of gender equality?

96. The beneficiaries of BReST and their spouses claim that the allocation of the cash benefit enabled joint decision-making within the household on the use of the money. More specifically, families report that the payment creates a suitable space for dialogue between the beneficiary and her partner. On this occasion, the family would take the time to discuss the type of expenditure and investments to be prioritised for children and for the household (for example the purchase of ruminants).

97. The ability to handle the benefit independently translates into a feeling of autonomy commonly reported by the beneficiaries during the focus groups. Indeed, the evaluators Women in fact say in focus groups that for many of them, BReST has allowed them to manage money when before they were not used to doing it. In this vein, it appears as though BReST contributed to forging the empowerment of women beneficiaries.

98. While, as some gender analyses note, money management can generate intra-household conflicts (Buler et al, 2018), the evaluators note that, on the contrary, BReST favoured money management at the household level. Moreover, in some cases men would state that by facilitating an extra income for the household, the benefit made it possible to reduce the pressure on the man as sole breadwinner of the family. In focus groups, the evaluation team often heard that the benefit made it possible to secure household income and alleviate the responsibilities of man as the main responsible supplier of household income.
99. Although men are not directly involved in the design of the project, the evaluators noted their voluntary participation in the support of mothers and children in health practices. During the focus groups, the men declared that they had followed the lessons on hygiene and health practices with interest and reported specific examples of the messages that were relayed locally.

**PRELIMINARY CONCLUSIONS: GENDER, EQUITY AND HUMAN RIGHTS**

**GEHR 1.** BReST's gender and human rights approach is insufficient because of the non-integration of the role of men and wider community members. BReST project directly tackles gender disparities by targeting women and their babies, thereby aiming to remove barriers that prevent equal access to health services during key stages of the lifecycle and to promote good nutritional practices. Adequate targeting is a first measure towards a gender-sensitive approach, but it is not sufficient. The integration of spouses, grandmothers and other members of the community, especially the older generation, in sensitization actions would have contributed to achieving more optimal results [Par 90, 91].

**GEHR 2.** Operationally, BReST's mechanisms of action are effective, in the way they address the barriers that prevent girls' and women's access to the services. BReST's mechanisms act effectively on barriers to access health services while promoting the application of lessons learnt on nutritional and health messages. Improvement in mothers and children’s health and nutrition status is recognized as a visible effect, in line with a right-based approach. Likewise, providing cash transfers is an effective measure to promote adequate nutritional patterns and diversification along with investment opportunities resulting in women's economic empowerment. As such, beneficiaries stretched the importance of the benefit, both in terms of money management and decision-making agency within the household [Par 92-94].

**GEHR 3.** BReST effects are more limited in terms of contributing to women’s voice and agency in their communities, via a greater participation in decision-making in local affairs [Par 95].

**GEHR 4.** An unexpected effect of the project is found in an improvement of intra-household gender dynamics. At the household level, without being specifically established as an expected result, the project has effectively created positive dynamics within the family, enabling spaces for dialogue between the beneficiaries and their spouses regarding the use of the benefit. Far from creating intra-household conflicts, the benefit was acknowledged to reduce the pressure on the breadwinner while granting flexibility to the beneficiary in the allocation of money, as shown by the numerous examples of investment observed locally. In general the willingness of spouses to participate in the process could start a wider process of increased husband’s participation in care [Par 97, 99].
5 Final Conclusions

The final conclusions are primarily drawn from the evaluation findings. The chapter has been structured along the evaluation criteria, summarising key findings and analysis for each of the criteria i.e. relevance, impact, effectiveness, efficiency, sustainability and gender and human rights.

<table>
<thead>
<tr>
<th>Evaluation criteria</th>
<th>Key conclusions</th>
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| **Relevance**       | • The evaluation concluded that BReST fits perfectly into the Gambian institutional framework, with a view to gradually extending the social protection schemes and tackling malnutrition. The project provides a comprehensive response to nutrition and health issues with a holistic approach combined with a monetary benefit and relevant nutritional and health support to the beneficiaries and their children.  
• The BReST project fits well the complementary programmes of other organization like WFP. The project did not start with a throughout analysis of social norms and habits. From the perspective of designing relevant interventions for pregnant mothers and very young children, the BReST project can provide valuable insights for other countries or for further development of similar interventions in The Gambia. |
| **Impact**          | • The project displayed positive effect on beneficiary children’s nutrition status, particularly during the lifetime of the project. In fact, during the two years of project implementation, acute malnutrition of beneficiary children progressively improved, and minimum dietary diversity during the project was found to be significantly higher among BReST beneficiaries compared to the rest of the population. However, some of these positive effects seem to fade as soon as the cash transfer stopped, as these gains were not observed post-project. The post project survey did not show evidence of a significant project effect on the prevalence of acute malnutrition, minimum dietary diversity and frequency of child meals.  
• Improved knowledge among beneficiaries translated to higher rates of exclusive breastfeeding, skilled delivery and hand washing practices.  
• The BReST project showed positive effects on household’s economic resilience by improving household productive capacity and savings. |
**Effectiveness**

- Though not initially part of the objectives, the project has a significant impact on birth certificate ownership among beneficiary children.
- The importance of the cash transfer within the BReST project illustrates that future programmes should definitely considered when designing similar interventions in other contexts; it should also be considered whether it is wise to end a cash transfer abruptly at a certain age of a child.
- The BReST project has reached its target of 10 Health Facility catchment areas and exceeded its target of 5,500 women with a total of 6,176 women registered and between 5,556 and 5,898 women received the cash transfers each month.
- The BReST project contributed to building national capacity to implement social transfers projects and to generate evidence on the results achieved on the ground. The BReST project was for the most part implemented by national institutions including NaNA, DSW and MoH, with coordination from UNICEF. However, more efforts need to be done to make training more frequently available to all project staff.
- The BReST has been effective in changing the behaviour around breastfeeding, birth registration and diets. It is troubling that the behavioural change in terms of food diversity and meal frequency did not result in long term changes due to the fact some families proved to be too poor to sustain the behaviour after the cash transfer was stopped.

**Efficiency**

- Overall, the cash transfer of GMD 600 per month, or roughly 25% of monthly per capita expenditure, is meaningful in helping the households improve care and nutrition of the children.
- The composition of the project expenditures shows a cost-efficient operation.
- The role of social workers was crucial, but their number was relatively small, and the equipment provided to them was limited.
- Cash plus interventions like the BReST project need to be designed with great care. Two elements proved to be important in this particular case: the adequacy of the cash transfer diminished for mothers who faced high transportation costs because they live in remote areas; the social workers needed to efficiently run and support this kind of programmes need to be sufficient in number while they need to be prepared well to function efficiently.
### Sustainability
- There is a good level of ownership and achievements resulting from the project as proved by the application of good health practices promoted through the education sessions.
- Sustaining the changes that have been realised through the BReST project will require a long-term vision the role that a project like BReST or similar could play in the social protection fabric of the country.

### Gender, Equity and Human rights
- BReST's mechanisms proved effective in addressing barriers that prevent girls' and women's access to the services, in particular health and nutrition services.
- The project did not fully involve men in the mechanisms of action: they could play in promoting good care practices within the household.
- The gender aspects of intra-household dynamics were not fully addressed as part of the BReST project; in similar projects, the outcomes of the interventions may be even more outspoken when the details would be designed to address gender issues within the households and within the communities.
6 Lessons Learned

While documenting Lessons learned, focus has been both on what worked particularly well in the BReST project and what could be improved in similar interventions elsewhere. These lessons may contribute to design and implement nutrition and health programmes in combination with cash transfers.

Four main lessons learnt came out of the evaluation.

**Lesson 1.** Integration of services toward the child at the same place as the cash disbursement has the potential to increase the coverage of these services, and hence improve the fulfilment of the rights of the child. The feature in the design of the BReST programme has worked particularly well and deserve to be considered in similar interventions.

**Lesson 2.** Regular and predictable cash transfers, in addition to counselling in IYCF, are powerful in combination in improving feeding practice and health and nutrition status. This lesson supports the idea to pay more attention to cash plus programmes and to interventions that either provide cash only or training and advise only.

**Lesson 3.** An adequate baseline and evaluation planned from the onset of the project allow to make more precise and stronger conclusions about the impact of the project on its beneficiaries. No social Policy intervention should be designed without an adequate monitoring and evaluation plan; within that plan an adequate baseline survey and a robust and accessible monitoring set up are indispensable tools.

**Lesson 4.** Analysing the roles and responsibilities of both men and women in projects seeking improved health and nutrition status of women and children during the design stage is key, since appropriate targeting of the sensitization activities has the potential to increase the impact of the behavioural change communication and bring primary care-givers (men and women) to invest more in better child feeding practices during and at the end of the project.

**Lesson 5.** The arrangements both with implementing partners and Civil Society proved very efficient and demonstrates that the model designed for BReST can serve as a reference for other cash transfer programmes in the region.
7 Recommendations

Strategic and operational recommendations addressed to evaluation expected users were developed by the evaluation team based on the key conclusions and further discussed and validated during a workshop with the key stakeholders.

### 7.1 STRATEGIC RECOMMENDATIONS

<table>
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<tr>
<th>Corresponding findings</th>
<th>Recommendations</th>
<th>Target Group</th>
<th>Priority</th>
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<tbody>
<tr>
<td><strong>Findings #83, 84, 90</strong></td>
<td>1) <strong>Capitalize on existing knowledge at the central and regional level for the ongoing design of the Social protection strategy and policies. More specifically:</strong></td>
<td><strong>UNICEF Country Office in The Gambia</strong></td>
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<td></td>
<td>a) Strengthen capacity of the social protection secretariat for coordination and knowledge capitalization/sharing and strengthen relations with the newly created Ministry of women affairs, children and social welfare</td>
<td><strong>National Secretariat for Social Protection</strong></td>
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<td>b) Under the coordination of National Secretariat for Social Protection, ensure continuous trainings on specific social protection topics with actors involved in implementation of social protection projects at national and regional levels. Some topics detected as necessary during the training are:</td>
<td><strong>Ministry of Women Affairs, Children and Social Welfare</strong></td>
<td><strong>HIGH</strong></td>
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<tr>
<td></td>
<td>• Single registry and social protection in an interconnected system</td>
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<td></td>
<td>• Monitoring and evaluation</td>
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<td>• Cash transfers and inter-sectorial policies.</td>
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<td></td>
<td>c) Present the evaluation at the social protection forum to share lessons learnt and good practices, and to advocate for more investment for such projects</td>
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<td></td>
<td>d) Work closely with the National Assembly to advocate for a line in the national budget and to ensure that the funds are actually disbursed</td>
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<td><strong>Finding # 92, 94, 97</strong></td>
<td>2. <strong>Extend the individual approach to the household and community approach: Social cash transfers should be targeted to the household and community instead of the individual</strong></td>
<td><strong>National Secretariat for Social Protection</strong></td>
<td><strong>MEDIUM</strong></td>
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<tr>
<td></td>
<td>Although the BReST design is relevant and integrates a gender perspective by targeting women</td>
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during the post-natal cycle and in complementarity with the prenatal support delivered by MCHNRP, it is still necessary to fully include the role of men in the mechanics of projects targeting women/children. An essential component to ensure a broader targeting constitutes the sensitization component. Indeed, by enlarging the sensitization to the whole family, the behavioral change could reach greater impact. To this end, it is essential that support is provided not only to beneficiaries, but also to other household members, and extended to communities.

Findings #1, 2, 3, 5

3. **Pursue the efforts in reducing Malnutrition and improving Resilience under a sustainable national Social protection strategy, with a focus on institutional dialogue and capacity building**

| National Secretariat for Social Protection |
| Ministry of Women Affairs, Children and Social Welfare |
| **HIGH** |

Findings #53, 81, 89

4. **Build on existing capacity, improve the number of social workers and value their image. More specifically:**

   a) Develop a strategy to train more social workers and increase their presence in the field given the importance of their role.

   b) Support a continuous process of skills development, building on those acquired during the project implementation, namely: knowledge on social protection, guidance in referral processes and direct action with the families.

| Ministry of Women Affairs, Children and Social Welfare |
| **HIGH** |

Findings #85

5. **Increase the involvement of Regional governments and Department of Community Development in project implementation for better coordination and sustainability**

The Regional government plays an important role in terms of coordination, supervision and advocacy in their respective regions. A more active implication of local communities is crucial.

| National Secretariat for Social Protection |
| Regional government |
| **MEDIUM** |
administrations has the potential to improve sustainability, as they can advocate for more funds for projects to the central government.

### 7.2 OPERATIONAL RECOMMENDATIONS

<table>
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<tr>
<th>Corresponding findings</th>
<th>Recommendations</th>
<th>Target Group</th>
<th>Priority</th>
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</table>
| Findings # 26, 39, 40, 41, 42, 43, 94, 95, 98 | **6. Continue to use regular and predictable cash transfers as a tool to increase economic resilience, children’s nutrition and health status and women empowerment**  
The flexibility provided by cash allows women/households to invest in what is important for their household, i.e. food (in particular for children) and productive assets and activities. Giving the cash to women increases their economic and social empowerment. | UNICEF Country Office in The Gambia  
National Secretariat for Social Protection  
Ministry of Women Affairs, Children and Social Welfare | MEDIUM |
| Finding #65 | **7. Reduce the cost for beneficiaries in obtaining benefits by bringing payment points closer to them.**  
In line with the National Health Strategy which stipulates that health facilities should be located within 5km distance from communities, the payment sites could be reorganized to follow this principle. | National Secretariat for Social Protection | LOW |
<p>| Finding # 51 | <strong>8. Ensure that social protection training programs are provided to all project staff and organized on a continuous basis, with priority given to new staff.</strong> | National Secretariat for Social Protection | LOW |</p>
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| **9. Establish an adequate baseline at the launch of the project** | The baseline constitutes an essential reference to adequately monitor and evaluate a project, in particular, when quantifiable indicators are previously established in the expected outcomes. Having a baseline is essential if the real impacts of any project are to be assessed. | **UNICEF Country Office in The Gambia**  
**National Secretariat for Social Protection**  
**HIGH** |
| **Findings #13** | **10. Reinforce the monitoring system with proper monitoring tools,** which will collect in a consistent and standardized way relevant data in all of the project sites. Relevant data can include, among others, basic demographic characteristics, child’s gender and date of birth, in addition to health information like anthropometric measurements and use of health services. | **UNICEF Country Office in The Gambia**  
**Ministry of Health**  
**Ministry of Women Children and Social Welfare**  
**National Secretariat for Social Protection**  
**HIGH** |
Annex 1. References


Musukuta Badjie, Yaya S Jallow, Almamo Barrow, Oumie Sissokho, Fanta Jatta Sowe, Qualitative study on gender dynamics in intra-household spending in West Coast and Upper River regions of the Gambia, January 2019.


mixed methods analysis from the MAM’Out randomized controlled trial. Cost Eff Resour Alloc 16, 13`


UNDP. (2018). Table 1. Human development index and its components.


Annex 2. Evaluation terms of reference

TERMS OF REFERENCE

SUMMARY

The United Nations Children’s Fund (UNICEF) is mandated by the United Nations General Assembly to advocate for the protection of children’s rights, to help meet their basic needs and to expand their opportunities to reach their full potential. The UNICEF staff and experts/consultants should act in accordance with the UN Code of Conduct and UNICEF Mission.

<table>
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<tr>
<th>Type of Contract (tick the appropriate box)</th>
<th>Institutional Contractor</th>
<th>Institutional</th>
<th>Technical Assistance</th>
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<tbody>
<tr>
<td>Nature of the Assignment</td>
<td>To conduct an end of the project evaluation of “Building Resilience for Nutritional Security in The Gambia through social transfers (BReST) 2016-2019” in Gambia</td>
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<tr>
<td>Location</td>
<td>Home, Banjul and Field work</td>
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<td>Duration</td>
<td>August to December 2019</td>
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1. Country Context
The Gambia, was ranked 174 out of 189 countries in the 2018 UN Human Development Index. With an annual growth rate of 3.3 percent, the projected population stands at 1.9 million (National Census, 2013). Life expectancy is 61 and 63 for male and female respectively (WHO, 2019). Trends in Infant and under-five mortality rates (IMR, U5MR) have been on the decrease as reported by the Demographic Health Survey (DHS) 2013 compared to the Multiple Indicator Cluster Survey (MICS) 2010. The data showed that between 2010 and 2013, infant mortality declined from 81 to 34 deaths per 1,000 live births. During the same period, under-five mortality declined from 109 to 54 deaths per 1,000 live births (MICS 2010 and DHS 2013).

Income poverty remains concentrated in rural areas, particularly among households headed by subsistence farmers and unskilled workers (with poverty rates of 79.3 percent and 65.4 percent, respectively). Integrated Household Survey (IHS 2010) data showed higher poverty rates among children 0-5 years of age (55.6 percent headcount rate) and 6-14 years of age (55.8 percent), as well as among adults aged 65 years and above (57.9 percent).
Under-nutrition is a problem in the Gambia that in recent years has been exacerbated by increasing poverty levels and food insecurity, poor coverage of nutrition interventions, poor dietary habits, poor sanitation and hygiene, and increased disease burden. The Gambia Micronutrient Survey (GMNS) 2018 showed that 15.7 percent of children aged 6–59 months five are stunted, 5.8 percent are wasted, and 10.6 percent are underweight. These figures have shown significant improvements from the 2013 Demographic and Health Survey (DHS) which measured stunting in children under five at 24.5 percent. Coverage of micronutrient supplementation is relatively low, with only 10.8 percent of households in the country using iodized salt. 60.6 percent of children aged 6 – 59 months are Vitamin A deficient and 65.7 percent are iron deficient (GMS, 2018).

Furthermore, The Gambia continues to face rising malnutrition rates linked to chronic food insecurity and a deteriorating ability of rural communities to cope due to recurrent climate change, erratic rains and an agricultural crop failure in 2018. Gambia rural poor’s well-being is negatively affected by a combination of the erratic funding of services and the poor implementation of policies to address certain aspects of poverty including malnutrition that can have long term effects on lives of children. Strategic intervention is required such as to provide timely and adequate resources and services for the health, education and livelihoods of Gambia children in the first 1000 days of life.

2. Evaluation object

Under these circumstances, UNICEF, the National Nutrition Agency (NaNa) and the Department of Social Welfare started implementing jointly the “Building Resilience through Social Transfers for Nutrition Security in The Gambia (BReST)” programme, supported by the European Union (EU) with a total budget of 3 million Euro for three years (2016 -2019). Its main rationale was to build resilience and improve nutrition status of lactating women and children under 2 years old in three of the country’s region: North Bank Region (NBR), Upper River Region (URR), and Central River Region (CRR).

More specifically, the BReST purpose and specific objectives were formulated as follows:

Purpose:
- Reduction in prevalence of acute malnutrition in children under two enrolled in the programme of this Action by 10%

Specific Objectives:
- Improved nutrition status and care practices for women with children under 2 by providing cash transfer and resilience building
- Improved implementation of related Government Policies through building capacities of government partners and civil society organizations.
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

The BReST is complementary to the World Bank-funded Mother and Child Nutrition and Health Results Project (MCNHRP) which focuses on better care for pregnant women and is expected to run until July 2019.

The BReST Program consisted in the provision of services aimed to improve the nutrition and care of the babies belonging to women targeted by the MCNHRP during their first 1,000 days of life. The BReST provides Social Cash Transfers (SCT) of 600 Dalasi (D) or about 9 EUR to these mothers, coupled with a systematic effort to increase their knowledge, monitor the growth of their babies, and induce changes in nutritional and caring practices.

Stakeholders in the BReST include:

- Government of the Republic of The Gambia (GoTG)
  - Ministry of Health (MOH)
  - Ministry of Finance and Economic Affairs (MOFEA)
  - Ministry of Women, Children and Social Welfare (MOWCSW)
  - Ministry of Lands and Regional Governments (MOLRG)
  - National Nutrition Agency (NaNA)
  - The National Assembly (NA)
- United Nations System Organizations in The Gambia
  - United Nations Children’s Fund (UNICEF)
  - World Food Programme (WFP)
  - Food and Agriculture Organization (FAO)
  - United Nations Development Programme (UNDP)
  - World Bank (WB)
- Cooperating Partners and other stakeholders
  - The European Union Delegation in The Gambia (EUD)
  - National Association of Cooperative Credit Unions (NACCUG)
  - BReST project beneficiaries

The European Union commissioned two Results Orientation Missions (ROM) in 2017 and 2018 respectively, these ROM mission were aimed at assessing ongoing implementation progress against the desired project objectives. These missions provided key insights and findings against OECD-DAC evaluation criteria as well as recommendations. These ROM reviews led to some revision of the programme especially in monitoring and data collection including an evaluation. As project is nearing its end and in compliance with project agreement, an end of the project evaluation is called for to have an external and independent insight into the performance of the programme, lessons learned, recommendations for future programmes and policy discussion around social protection in the Gambia.
3. Evaluation Purpose

This evaluation has twofold purposes: accountability and learning. As the Project is ending in February 2020 to accommodate an evaluation, this summative evaluation would provide key stakeholders (UNICEF, The National Nutrition Agency, The Ministry of Women, Children and Social Welfare, European Union, beneficiaries) with solid evidence about the effectiveness, efficiency, relevance and sustainability of the BReST Project and its potential impact on quality nutritional and social protection outcomes in Gambia (accountability purpose).

Furthermore, the evaluation findings and recommendations will provide strategic direction to the UNICEF Country Office in The Gambia and a wide range of stakeholders (including development partners and policy makers) for the design and implementation of subsequent social protection programmes as well as well for the support of the ongoing and future country efforts to attain improved nutritional and social protection outcomes. Key recommendations and lessons learnt will also enable the Government, UNICEF, and key stakeholders to enhance the effectiveness of their ongoing social protection advocacy work.

This evaluation will also support the UNICEF Country Office in The Gambia to reflect and determine the most viable strategic direction not only deliver better results for the most vulnerable children today but also to strengthen the formulation of UNICEF next Country Programme in line, among others, with UNICEF Strategic Plan and SDGs outcomes. The overview of expected Users and Uses of the evaluation results is presented in Table 1 below.

It is worth noting that this evaluation is commissioned by UNICEF as the primary contract holder of the BReST project grant in partnership with the National Nutrition Agency and the Ministry of Women, Children and Social Welfare (MOWCSW). However, all the evaluation findings and recommendations will be discussed with all the participating agencies, the donor (the European Union) and the relevant ministries, according to the guidelines and procedures spelled out in the BReST project design and project operational manual. While UNICEF Gambia Country Office Senior Management will issue a management response, the applicability of the overall lessons learned, and best practices is expected to inform and benefit the future programming in the social protection domain, among the Government counterparts, the implementing agencies and other technical and development partners.

<table>
<thead>
<tr>
<th>Evaluation Users</th>
<th>Evaluation Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF</td>
<td>To inform and adjust where required as per their Country Programme Strategy for the period 2017-2020 by better understanding the contributions of the BReST Project</td>
</tr>
<tr>
<td>Development Partners in Social Protection (World Bank, UN Partners, etc)</td>
<td>The UNICEF Social Protection Section, in collaboration with all other partners involved in the implementation of the UN Development Assistance Framework (UNDAF), will benefit to identify strategic/implementations changes to their strategy. Development partners working in Social Protection will benefit to obtain lessons learnt and recommendation from the evaluation for</td>
</tr>
</tbody>
</table>
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

| Programme design and strategic direction in National Social Protection Strategy and Programme. | Donors | Will better articulate the outcome and impact of their interventions and inform future interventions |
| Government (Including NaNA) | Will better define the terms of collaboration with UNICEF with respect to the attainment of the relevant goals set in the National Development Plan |
| NGOs/CSOs | Mainstream (into their day-to-day practices) the good practices identified during the evaluation and address the weaknesses emerged during the analysis |

4. Evaluation Objectives

The Objectives of the Evaluation are:

- Determine the relevance, effectiveness, efficiency, sustainability and impact of the BReST programme;
- Assess the extent to which the programme has integrated equity, gender and human rights principles in its design, implementation and monitoring and succeeds in reaching the most vulnerable groups (extremely poor, hard to reach communities, marginalized groups and other disadvantaged groups);
- Identify unmet priorities of the BReST project as well as unexpected outcomes (positive and negative);
- Provide evidence-informed findings, lessons learnt, and specific actionable recommendations to contribute to the planning and strategic discussion of a successor programme in social protection sector as per The Gambia National Social Protection Policy 2015-2020 as well as UNICEF strategic document;
- Identify good practices and provide evaluation brief(s) for policy advocacy and communication purpose based on the evaluation report

5. Evaluation Scope

Thematic scope:
The Evaluation will cover the implementation of the entire project period (August 2016 to October 2019). While the project field activities (i.e. cash transfer, advocacy and Infant and Young Child Feeding Practices education components) will phase out in October 2019, the project will official end February 2020 to enable the end line evaluation and asset transfer to be conducted.

Following the ROM reviews of the project in 2017 and 2018 respectively, following major adjustments were carried out in the design and implementation for the projects as below;
- The outcome statement of the project was amended
- The project end date was extended to February 2020
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

- The planned field activities for the end line evaluation is to be conducted between October and December 2019 following inception phase
- The budget was amended to cater for the proposed changes
- The workplan for the action also amended to cater for the implementation of the proposed changes to the action

Geographical scope:
The evaluation will cover all the three intervention regions of BReST with interaction with national, provincial, district and community level stakeholders. The evaluation team is expected to undertake field trips to the intervention areas to ascertain the contribution of the project and to solicit beneficiary perspectives. The field site to be visit shall be selected based on well-established criteria and sampling strategy by the evaluation team in consultation with UNICEF Gambia, The National Nutrition Agency and The Ministry of Women Children and Social Welfare. A minimum of four health facilities and three communities in each of the three implementation regions shall be visited. Larger number of sites may be proposed for quantitative data collection. The technical proposal submitted by the firm should include a list of suggested criteria and provide more details on the sampling.

6. Evaluation Criteria
This evaluation will be guided by the following OECD/DAC criteria (Relevance, Effectiveness, Efficiency, Impact and Sustainability) and an additional one on Gender, Equity and Human Rights.

7. Evaluation Questions
To attain the evaluation purpose, the evaluation team will address the following questions (grouped by criteria). The evaluation questions are expected to be further refined by the evaluation team during the inception phase; the evaluation matrix provided in the inception report shall also detail the source that will provide the data necessary to answer each individual question.

I. Relevance
1.1 To what extent are the BReST Project’s interventions aligned with the Gambia Government’s identified priorities i.e. the National Social Protection Policy and The National Development Plan?
1.2 To what extent does the BReST programme respond to the identified needs among its expected beneficiaries?
1.3 How complementary are the UNICEF’s BReST interventions with those implemented by the World Bank, government and other partners to reach the most vulnerable? What are the areas where complementarity was lower than expected?
1.4 To what extent were the Project’s expected results clearly stated and measurable through identifiable indicators and disaggregated by sex and age?
1.5 To what extent were the BReST programme logical framework and theory of change realistic in the way they described the Programme outputs, outcomes, and impact and that different implementation strategies to attain them?

1.6 To what degree were the programme interventions based on a thorough review of cultural and social norms?

II. Effectiveness

2.1 To what extent did the BReST programme achieve its expected results?

2.2 To what extent did key nutrition, health, and other pre-defined indicators change in the targeted districts?

2.3 To what extent has the programme contributed to behavioural change in nutrition and care practices in the targeted communities? Were the behavioural change strategies and communication used appropriate to achieve the expected results?

2.4 What are the programmed unintended and unexpected results (both positive and negative)?

2.5 What internal factors to UNICEF (including the programme monitoring and evaluation mechanisms, the level of key actors’ participation and ownership, the quality of service delivery and demand for services with consideration of equity and gender) contributed to or hindered the successful attainment of the expected results? Which factors were the most important?

2.6 What external factors to UNICEF (e.g. political, emergency or socio-cultural barriers) contributed to or hindered the successful attainment of the expected results? Which factors were the most important?

III. Efficiency

3.1 To what extent have human, financial and material resources been:
   - adequate (in quantity)
   - sufficient (in quality) and
   - distributed / deployed in a timely manner for the implementation of the programme?

3.2 What could have been done to attain the same BReST programme objectives but at a lesser cost?

IV. Sustainability

4.1 To what extent did the programme identify and build on existing national and local, civil society and government capacities, structures and mechanisms to avoid dependency on the UNICEF funds over time?

4.2 To what extent were the programme achievements sustained and for the most recent ones how will they be sustained when external support ends?

4.3 What has been done and what can stakeholders do more to ensure that programme achievements are kept and improved further over time?

4.4 What are the main strengths and challenges in relation to ensuring that the programme achievements are kept over time both at the community and institutional levels?

V. Impact

5.1 Is there any lasting change that could be identified in the lives and well-being of pregnant and lactating women (and their children) targeted by the BReST programme?
5.2 To what extent have the programme contributed to changes in mortality and morbidity among the women and children targeted by the BReST programme?

5.3 To what extent has the programme contributed to increase the resilience of the targeted households?

VI. Gender, Equity and Human Rights

6.1 To what extent were Gender, Human rights and Equity principles duly integrated in the design, delivery and monitoring of the programme?

6.2 To what extent did the BReST programme tackle the barriers that prevents’ girls and women’s access to the services that it made available in the targeted communities?

8. Methodology

The evaluation will be conducted using a participatory and inclusive approach to provide relevant and pertinent answers to the identified evaluation questions. The overall exercise will be conducted according to UNEG Norms and Standards for Evaluation. It will integrate human rights, gender and equity in accordance with the relevant UNEG guidelines and will be conducted in accordance with the UNEG Code of Conduct and Ethical Guidelines for Evaluation and comply with UNICEF standards on research involving children if applicable.

The evaluation will be based on the use of qualitative and quantitative methods (mixed methods), both during the data collection and analysis phases. Relevant data should be collected from programme beneficiaries and key implementation stakeholders and partners. Primary data collection will involve qualitative and quantitative data collected through key informant interviews, focus group discussions, community meetings, observations, surveys and other relevant methods suggested by the evaluation team.

Secondary data will also be gathered and reviewed by the evaluation team. The desk review will include, among others, a review of programme reports; surveys and monitoring reports; reports of similar evaluations, as well as internal and external research, studies and databases.

8. Preliminary Timeline and Evaluation Deliverables

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Deliverables</th>
<th>Proposed Number of days (To be defined in the technical and financial proposal)</th>
<th>Tentative Timeframe (2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Team leader</td>
<td>Team member(s)</td>
</tr>
<tr>
<td>I.</td>
<td>Preparatory phase</td>
<td>Inception Report (details below)</td>
<td>5</td>
</tr>
<tr>
<td>1.</td>
<td>Document Review, preliminary interviews with key stakeholders, elaboration of the inception report</td>
<td>Inception Report (details below)</td>
<td>5</td>
</tr>
</tbody>
</table>
## End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Deliverables</th>
<th>Proposed Number of days (To be defined in the technical and financial proposal)</th>
<th>Tentative Timeframe (2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Team leader</td>
<td>Team member(s)</td>
</tr>
<tr>
<td>2. Review of the inception report by the Evaluation Reference Group and integration of comments</td>
<td>Approved inception report</td>
<td>2</td>
<td>2</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>II. Field data collection phase</td>
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<tr>
<td>3. Data collection including field visits</td>
<td>Raw data set including responses to questionnaires, interview notes, etc.)</td>
<td>15</td>
<td>15</td>
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<tr>
<td>4. Debriefing on preliminary findings (in-country)</td>
<td>Power Point Presentation at a meeting to be held with the BReST Evaluation Reference Group accompanied by summary briefs</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td>III. Data analysis, report writing, validation and dissemination</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. Data analysis and elaboration of draft evaluation report based on the ERG inputs</td>
<td>Draft evaluation report reflecting the inputs from BReST ERG meeting</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
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<tr>
<td>6. Review of the draft report by the Evaluation Reference Group</td>
<td>Reviewed evaluation report</td>
<td>-</td>
<td>-</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>7. Recommendation validation workshop</td>
<td>Recommendations are fine-tuned and approved by the stakeholders, management response plan drafted</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. Integration of comments and submission of final evaluation report</td>
<td>Final evaluation Report (details below)</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>9. Develop an evaluation policy brief based on the final approved evaluation report, update the PPT and 1 human interest story</td>
<td>Evaluation Brief for policy makers</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1 Power Point Presentation summarizing final evaluation report</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 Human interest story (HIS)</td>
<td></td>
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</tbody>
</table>
### End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Deliverables</th>
<th>Proposed Number of days (To be defined in the technical and financial proposal)</th>
<th>Tentative Timeframe (2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Final review and policy briefs, HIS and PPT by ERG</td>
<td>Reviewed evaluation products</td>
<td>-</td>
<td>December 2019</td>
</tr>
<tr>
<td>11. Submission of final evaluation briefs, PPT, HIS</td>
<td>Final Evaluation Brief, Final Power Point Presentation, Final Human interest story</td>
<td>2, 1</td>
<td>1st week of January 2020</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>40, 37</td>
<td></td>
</tr>
</tbody>
</table>
Details on Deliverables

1. Inception Report:
   - Introduction presenting the object of the evaluation, its purpose, scope and objectives;
   - Preliminary results of the documentary review summarized in the evaluation context section;
   - Evaluation criteria and questions refined through the desk review and preliminary interviews;
   - Detailed description of the evaluation methodology, including relevant data collection methods that will allow answering evaluation questions and sampling strategy;
   - Evaluation matrix presenting for each evaluation criterion and each evaluation question planned data collection methods and data sources.
   - Methods of data analysis;
   - Limitations of the evaluation and section on ethics and ethical considerations
   - Work Plan
   - Annex: List of the main documents reviewed; Proposed data collection tools; Initial list of key informants.

2. Power Point summarizing key preliminary findings
   - The Consultant will present the preliminary findings in Power Point Format with a summary hand-out. This will include the key points from the documentary review, emerging findings from preliminary data analysis and key ideas for recommendations. Participants of this meeting may seek clarity on findings or methodology and it is expected that the consultant will fine tune the findings, conclusions and recommendations thereafter.

3. Draft evaluation report

4. Recommendation validation workshop
   - Workshop to be facilitated remotely or by national consultant, as agreed with UNICEF

5. Final Evaluation report (max 50 pages with the rest to be placed in annexes)
   - Table of Contents including List of Tables and List of Figures
   - Executive Summary (covering all main sections of the report: background, methodology and process, main findings and recommendations, lessons learnt)
   - Acknowledgements (all who supported the evaluation and provided strong cooperation and collaboration during the process)
   - List of abbreviations and acronyms
   - Introduction (object of the evaluation, evaluation purpose including indented uses and users, objectives, scope)
   - Evaluation context
   - Methodology, including sampling strategy, data analysis methods, evaluation limitations and ethical consideration
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

- Key findings (organized by evaluation criteria and questions – each individual question needs to be answered) + Preliminary Conclusions (all findings paragraphs will be numbered, and each conclusion will need to make explicit reference to the number of the corresponding paragraph on which it is based)
- Final conclusions
- Lessons Learnt
- Recommendations (strategic and operational, maximum 5 priority recommendations)
- Annexes (ToRs; List of persons interviewed, and sites visited; List of documents consulted; More details on methodology, such as data collection instruments, including details of their reliability and validity; Evaluators biodata and/or justification of team composition; Evaluation matrix; Results framework and or Theory of Change)

6. Final Power Point Presentation which summarizes the Evaluation Report with slide(s) of Key findings, conclusions and recommendations;

7. Raw data in electronic medium, data collection instruments in electronic medium, transcripts in electronic medium, completed data sets, etc.
8. 1 Evaluation Brief
9. 1 Human Interest Story

9. Governance of the Evaluation

The evaluation team will be supervised and report to the UNICEF Regional Evaluation Advisor in close collaboration with The Gambia country team. The evaluation team will work with relevant Government Ministries, Departments and Agencies (MDAs), participating UN agencies and Cooperating Partners, as well as other intervention stakeholders, including beneficiaries.

As part of quality assurance mechanism and to ensure ownership, a reference group comprising of Government representative and relevant UNICEF staff will be established to provide oversight to the evaluation and provide comments to the deliverables (inception, draft, final evaluation report, evaluation briefs). The Regional Evaluation Advisor based at the UNICEF Regional Office for West and Central Africa (WCARO) will also provide technical oversight over the entire evaluation process, including on the different evaluation products described above.

10. Location, Payment and Duration
- This consultancy is both home based (desk review and write-up of final report) and on-site in The Gambia (primary data collection, presentation at the workshop)
- The presentation of the inception report shall be made to the BReST stakeholders Evaluation Workshop in Banjul between 16th – 23rd December 2019 which will require the
Consultant to be a key participant to present and engage in the validation, adding context/findings not included in the presentation as the need may arise.

- The assignment is expected to begin 1st week of September 2019 latest and the evaluation team is required to submit complete final evaluation report in December 2019. The exact number of days is to be proposed by the evaluation team and discussed with and confirmed, including the specific deadlines, by UNICEF when signing the contract.
- Advance payments are not allowed; the payment is against deliverables and the following scheme is applied:

<table>
<thead>
<tr>
<th>Payment</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upon approval of the inception report</td>
<td>20%</td>
</tr>
<tr>
<td>Upon submission of the draft report and PPT</td>
<td>30%</td>
</tr>
<tr>
<td>Upon approval of Final Evaluation Report and agreed number of policy briefs, HIS and PPT</td>
<td>50%</td>
</tr>
</tbody>
</table>

- UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if work/outputs is incomplete, does not meet the quality standards of both UNICEF and the Government of The Gambia, not delivered or has failed to meet deadlines (fees reduced due to late submission: 5 days – 10%, 15 days – 20%; 1 month – 50%; more than 1 month – payment withheld).

11. Evaluation Team Profile

11.1 Team leader
She/he will coordinate the evaluation team and will ensure the design of the evaluation, the management of the evaluation process, the quality assurance and the delivery of the expected products in close collaboration with the other members of the team. She/he shall conduct the evaluation applying an approach that is conducive to the transfer of competencies to the national members of the evaluation team. She/he should have the following profile:

- Master’s degree in Social Sciences, Social/Public Policy Management, Economics, Public Health or related social Protection graduate qualifications
- A minimum of 8 years of professional experience in designing, implementing and managing social protection, resilience or related programmes, including at least 5 years specifically in project evaluation
- Have a perfect command of quantitative and qualitative methods of research and evaluation methods based on equity, human rights and gender;
- Have excellent oral and written communication skills in English as well as skills in facilitation of participatory processes;

- Proven record of writing evaluation report (recommended to provide sample evaluation reports with proposals)
- Understanding of the development context in The Gambia will be an advantage

Have work experience in West Africa and The Gambia preferably
11.2 Evaluation Team Member(s)

It is expected that the evaluation team will be comprised of one or two additional members that will participate in all stages of the evaluation process and will be primarily responsible for collecting and analysing the data that will be used to establish the evaluative judgment. They will also contribute to the analysis of the national context and to contextualization of the results of the evaluation. The profile of the additional team member(s) should correspond to the following:

- Have at least Master’s degree in public health, nutrition, social sciences or other relevant discipline;
- Have at least 5 years of experience in evaluating development programmes and projects and social protection and nutrition interventions in particular;
- Have a perfect knowledge of the social protection and nutrition sector and the country specific context;
- Have a perfect command of quantitative and qualitative data collection and analysis methods;
- Have experience in the use of participatory appraisal techniques in data collection, sensitive to gender issues;
- Be familiar with the international literature and issues related to social protection, resilience and nutrition;
- Have excellent oral and written communication skills and English;
- Have excellent analytical, synthesis and writing skills
- Must have completed at least two high quality programme evaluations over the past 5 years

12. Selection process and modalities

The selection of the Evaluation firm/Consortium of evaluators will be made based on the technical and financial offers that shall be submitted according to the UNICEF procedures. The technical and financial offers will be scored using 100 points scales, including 30 points for the financial offer and 70 points for the technical proposal.

The technical proposal (15 pages maximum) should cover the following aspects:

- Understanding of the terms of reference
- Evaluation methodology
  - Methodological reference framework to address evaluation questions
  - Data collection and analysis methods
- Organizational capacity of the evaluation team to execute the mandate:
  - Evaluation work plan
  - Roles and responsibilities of evaluation team members
- Expertise and Experience of the proposed evaluation team (CV of no more than 3 pages per person)
  - Expertise and experience of the Team Leader (including ability to manage multiple teams at the same time)
  - Expertise and experience of other team members

A copy of at least one evaluation report produced by the Team Leader during the last 5 years should be attached to the application.
The Technical Proposal shall be submitted in a separate file or envelop, clearly named/marked: “Technical Proposal.” No financial information should be included in the Technical Proposal. The technical offers will be noted according to the assessment grid provided in Table 4.

<table>
<thead>
<tr>
<th>Number</th>
<th>Assessment criteria</th>
<th>Sub-criteria</th>
<th>Score</th>
<th>Total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Understanding of ToRs</td>
<td>Understanding of ToRs (according to the value added of the technical proposal)</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>Methodology</td>
<td>Methodological reference framework to address evaluation questions (according to the relevance of the methodological framework for answering evaluation questions)</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data collection methods (according to the relevance and consistency of the proposed data collection methods for answering the evaluation questions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data analysis methods (according to the relevance and consistency of the proposal for answering the evaluation questions)</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Organizational capacity of the evaluation team to execute the mandate</td>
<td>Evaluation Work Plan (according to the relevance of the proposed timeline for the delivery of expected outputs)</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Roles and Responsibilities of the Evaluation Team members (according to the appropriateness of the distribution of roles and responsibilities for the achievement of expected results within the required time)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Expertise and experience of the Team Leader</td>
<td>Expertise of the Team Leader (according to the conformity with the required profile and the expertise evaluation in general and in equity-focused and gender and human rights-based evaluations)</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experience of the Team Leader</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

<table>
<thead>
<tr>
<th>5</th>
<th>Expertise and experience of the Evaluation team members</th>
<th>Expertise of the team members (according to the conformity with the required profile, the expertise in the targeted thematic area, knowledge of the national context and evaluation and research methods)</th>
<th>6</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Experience of the team members (according to the experience in evaluation in general and in the thematic targeted area)</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

**Total Score attributed to the technical proposal** 70 points

The financial proposal shall contain the Offer with cost breakdown and must cover all expenses related to the evaluation including the desired remuneration, accommodation costs, travel costs (economy class), travel insurance and others. The IT and communication equipment necessary for the proper implementation of the evaluation will be the responsibility of the Evaluation firm/Consortium of consultants. It should be noted that the costs of organizing meetings or technical workshops will be borne by UNICEF. The financial offer will be presented separately from the technical offer and clearly named/marked Financial Proposal. It will only be examined for candidates whose technical offer is considered technically valid (minimum score of 50 points).

14. Intellectual property rights

UNICEF shall be entitled to all property rights, including but not limited to patents, copyrights, trademarks, and materials that bear a direct relation to, or made in consequence of, the services provided. At the request of UNICEF, the consultant shall assist in securing such property rights and transferring them to UNICEF in compliance with the requirement as is applicable.

15. How to apply
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

Applicants are strongly encouraged to email their technical and financial evaluation offers (proposals should be submitted separately, to the following email address fsenghore@unicef.org

Deadline for applications: 13th July 2019
ANNEX 1

BReST Project theory of Change

The landmark lancet series on Maternal and Child Health, shows that the first 1,000 days are critical for a child’s physical and cognitive development (Black et al, 2008). The Series identified the need to focus on the crucial period of pregnancy and the first 2 years of life - the 1,000 days from conception to a child’s second birthday, during which good nutrition and healthy growth have lasting benefits throughout life. Some estimates suggest that focusing global efforts on nutrition in these first 1,000 days could reduce child mortality by 25 per cent and neonatal deaths by 35 per cent. More recent estimates propose that the right nutrition during the first 1,000 days could save more than one million lives each year. The 2003 Lancet Child Survival Series ranked the top 15 child survival interventions for their effectiveness in preventing under-five mortality. The report indicated that a combination of exclusive breastfeeding, continued breastfeeding until 12 months and optimum complementary feeding could prevent up to 20 per cent of under-five mortality in developing countries. Of all proven nutrition interventions, strong IYCF practice has the single greatest potential impact on child survival (Black et al, 2008).

The UNICEF conceptual framework clearly identifies three levels of causes of under-nutrition namely: immediate causes at the individual level (inadequate dietary intake and diseases), underlying causes (household food security, child and women care practices and health, environment and services) and basic causes (including income, economics, politics and governance).

Building on the three-level cause of under-nutrition approach developed by UNICEF referenced above, the authors of a 2009 journal article hypothesized that cash transfer programmes affect nutrition through a number of different mechanisms.

Figure 1 The impact of conditional cash transfer programmes on child nutrition: a review of evidence using a programme theory framework

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11 Black et al., 2008. The Lancet series on maternal and child undernutrition
13 http://www.unicef.org/nutrition/training/2.5/4.html
The project therefore proposes to work on two pathways to achieve improved nutrition status for children under 2 by: resilience building, providing cash transfers for nutrition security and improved caring practices for women and children through nutrition education. As highlighted earlier very high poverty rates are concentrated in those three focus regions URR, CRR and NBR. Household income is a critical factor in maintaining better nutrition and addressing nutrition security. In addition, knowledge, practice and behaviour of households are other important factors in adequately feeding children. Therefore, the project will use multiple intervention approach in addressing some underlying causes of malnutrition and mitigate risks that may lead to stunting in the longer-term.

✓ **Improved Household Income, Resilience and Nutrition**

The project will increase income of mothers through the monthly cash transfers which will enable the households to buy more diversified food. There is strong and established evidence from across Africa that social transfers are an effective and efficient way of achieving results in terms of consumption and nutrition security. (UNICEF-ESARO/Transfer Project (2015), ‘Social Cash Transfer and Children’s Outcomes: A Review of Evidence from Africa’.)

This model of social protection has multiple outcomes, most importantly through the contribution to building resilience and capacity of households in addressing food insecurity. Previous studies have shown that, poor households use most of the cash transfers to purchase...
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

food\textsuperscript{15} which in turn results in improved nutrition security for mothers and children through consumption of a diversified diet. Many programs report improvement in dietary diversity, and Hoddinott and Yohannes linked dietary diversity to household consumption and caloric availability, and pointed out its usefulness as an identifier of nutritional food insecurity\textsuperscript{16}. This method is preferred over vouchers or other means of directing where households spend the money due to its empowered choice.

UNICEF globally promotes and advocates for establishing inclusive and sound social protection programmes in developing countries to fight poverty and achieve sectoral outcomes. Currently, UNICEF is working with key national stakeholders to strengthen and improve the existing social protection system making it more inclusive and responsive to needs of vulnerable populations in the country. The government and communities will participate in the implementation of the project as a way to enhance their capacity to promote and implement nationwide social protection programming.

Building resilience of beneficiaries will be achieved through enhancing collaboration and synergy with other international organizations (World Bank, FAO, WFP) which are working on enhancing productivity in agriculture, food security, food supply chain and safety net.

\textbf{✓ Better nutrition practices for lactating women and children under 2}

This pathway focuses on the role of women and men in promoting better nutrition and child care practices. As noted from the results of the DHS, Gambia has poor infant and young child feeding practices. Of all proven nutrition related interventions, IYCF has the single greatest potential impact on child survival given that infant and young child feeding is important for improving nutrition outcomes among young children. Pregnant and lactating women will be incentivized to attend the infant and young child feeding and counselling sessions as well as infant welfare clinics which will result in increased knowledge and skills in improved child feeding practices including breastfeeding. Targeting the 1,000-day window is likely to also lead to significant reduction in stunting. Due to the short duration of the project, however, it is very difficult to significantly reduce child stunting and subsequently measure the impact. It is expected that the project will contribute to mitigating some risks that leading to stunting in the longer-term.


Annex 3. Short biography of the evaluation team

The Social Policy Research Institute (SPRI) is a not-for-profit institute engaging in research and research-based advisory services. Our experienced team consists of social policy specialists, economists, and early childhood development experts. Our team members have a strong academic background combined with hands-on social policy experience acquired as practitioners in countries around the globe. We currently engage in quantitative and qualitative empirical research projects worldwide in the following core areas: i. Poverty analyses, with an emphasis on multidimensional, non-monetary poverty; ii. SDG monitoring; and iii. Social protection design and evaluation.

The countries we have worked in include (but are not limited to) Kenya, Ethiopia, Angola, Botswana, Burundi, Cabo Verde, Algeria, Sierra Leone, Liberia, Guinea, Guinea Bissau, Lesotho, Libya, Morocco, Rwanda, Swaziland, Benin, Zambia, Zimbabwe, Cameroon, Togo, State of Palestine, Laos, Mongolia, Thailand, Cambodia, Myanmar, Tajikistan, and Democratic Republic of Congo.

The team for the BReST evaluation is composed of:

- Prof Chris de Neubourg: Team leader
- Magdalena Isaurralde: Senior researcher: Qualitative, quantitative and policy analyst
- Aminata Bakouan Traore: senior researcher, quantitative analyst and policy analyst
- Sinta Satriana: Senior researcher, social policy expert

The team members are well acquainted with the region specificities since they have done several researches on poverty and social protection in Africa. They have been working with UNICEF country offices in collaboration with government officials in Kenya, Ethiopia, Botswana, Zimbabwe, Lesotho, Swaziland, Angola, Zambia, Democratic Republic of Congo, Cameroon, Togo, Benin, Mali, Morocco, Guinea, Algeria, Libya, Sierra Leone, Liberia, Cabo Verde to conduct studies on children deprivations and social protection programmes. All the studies were contextualized, and research carried only after several missions in the countries to understand the complexity of child poverty, deprivation, and well-being in each.

Related expertise of team members

1. Prof. De Neubourg has worked, and is still working, extensively with UNICEF offices on Multidimensional Child Poverty Studies in more than 40 countries. He has been engaged in social protection projects with UNICEF, the World Bank, UNDP, the ILO, the Asian Development Bank and bilateral donors. Recently he has led the team that did the mapping of the social protections systems in Morocco and Guinea. He has ample experience in advising governments and international organisations on social policy reform.
2. Magdalena Isaurralde is as socio-economist cumulating 15 years of professional experience in social protection, microfinance, urban poverty, access to basic services and environmental risks. As Social Policy and Research specialist with UNICEF she has provided technical assistance in social policies’ design and implementation, including Cash Transfer programs design and evaluation. With SPRI, she was engaged in child multidimensional poverty analysis, elaboration of situation analysis of children and women (SITAN) and capacity building in social protection. She has worked in research and technical assistance in several African countries including Angola, Democratic Republic of Congo, Central Africa, Benin and Guinea.

3. Aminata Bakouan Traoré is a quantitative social protection and resilience specialist with 10 years of extensive experience in data analysis and policy formulation in the fields of social protection, poverty analysis and reduction, and resilience with among others the World Bank, the Food and Agriculture Organization of the UN, UNICEF and Oxford Policy Management (OPM). She has been working on mapping of social protection systems and social protection strategies, notably in Guinea, Morocco, and Cote d’Ivoire. Recently, she worked as a resilience technical advisor for the FAO, covering the Sahel and West Africa region. Aminata has an extensive experience in policy dialogue with country counterparts, project development and institutional strengthening.

4. Sinta Satriana has 15 years of experience in the fields of social protection, poverty and public health. She has provided governments with technical assistance in designing and monitoring social policies including by conducting innovative studies, program evaluations, impact assessments and capacity building activities. Previously as policy specialist with the ILO and UNICEF, she has been in charge of social protection policy assessments, technical oversight of Public Finance for Children and capacity building in data collection and data utilization. With SPRI, she has been involved in analysis of child-sensitive public budgeting, evaluation and impact assessments of social protection programs and development of training programs in social policies.
## Annex 4. Evaluation matrix

<table>
<thead>
<tr>
<th>Questions</th>
<th>Indicators</th>
<th>Data methods</th>
<th>Data source</th>
</tr>
</thead>
</table>
| 1. Relevance                                                             | National Development Plan (NDP) 2018-2021 - Priority "Investing in our people through improved education and health services, and building a caring society" | - Stakeholders’ views on the coherence of BreST objectives and strategies with the National Development Plan  
- Monitoring system in place for routine data collection on health and nutrition indicators | - Desk Review of relevant documents  
- Quantitative analysis of administrative data  
- KIIs with Office of the Vice President, NaNA, DSW, Ministry of Health, health workers and social workers  
- Field observations (at the National implementing agency and at the local level) | - National Development Plan  
- National Social Protection Policy  
- BreST monitoring system  
- Relevant stakeholders (including the BreST Sterring Committee and Project Management Team members; health workers and social workers at regional level) |

| 1.1. To what extent are the BreST Project’s interventions aligned with the Gambia Government identified priorities (i.e. National Social Protection Policy & National Development Plan)? | National Social Protection Policy (NSPP) 2015-2025  
- To what extent did the project contribute to the overall objective of the NSPP to progressively establish an integrated and inclusive social protection system, ensure more efficient and | - Existence of an efficient monitoring system to enhance the project management  
- Synergies between health and social | - Quantitative analysis of monitoring data  
- Qualitative analysis with KII (NaNA, DSW, HF)  
- desk review | - ROM evaluations  
- Project monitoring data |
**End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019**

| 1.2. | To what extent does the BReST project respond to the identified needs among its expected beneficiaries? | Does the design of the project include:  
- incentives for better knowledge of nutrition and health practices for young mothers;  
- relevant educational measures on these subjects (for example on breastfeeding)  
- accompaniment of mothers and their children;  
- sufficient financial incentive to promote the use of services  
To what extent did the Project address the needs that may have been identified through ad hoc needs assessment before the start of implementation?  
Does the design of the project address the needs of beneficiaries from a gender perspective? | - Health services utilisation;  
- Observation and monitoring of practices on exclusive breastfeeding  
- Quantitative analysis of monitoring data  
- KIIs of NaNA, DSW, UNICEF, VDGs and health facilities; desk review;  
- FGD with beneficiaries, VSG and VDG;  
- field observations  
- Project design and theory of change;  
- ROM evaluations  
- Needs Assessment conducted at the beginning or before the start of the projet  
- beneficiaries, VSG, VDG |
| 1.3. | How complementary are the UNICEF BReST interventions with those implemented by the World Bank, government and other partners to reach the most vulnerable? What are the areas where complementarity was lower than expected? | To what extent has the project been able to establish complementary links with the World Bank -Maternal and Child Nutrition Health Results Project (MCNHRP) - through:  
- the use of health services?  
- the coverage and reach of beneficiaries?  
- monitoring beneficiaries on the pre and postnatal cycles? | - Health services utilisation;  
- Integration of operational systems and institutional arrangements  
- KIIs of NaNA, DSW, health facilities, service provider and development partners such as WFP and WB,  
- desk review |
| 1.4. | To what extent were the Project’s expected results clearly stated and measurable through identifiable indicators and disaggregated by sex and age? | What indicators are available to be used to monitor the achievement of objectives?  
- To what extent the expected results of the project clearly stated?  
- What indicators have been identified to monitor the attainment of the Project’s objectives?  
- Are they relevant for measuring the overall objectives and specific objectives of the project? | - Availability of all indicators  
- Accuracy of indicators used versus defined objectives  
- KIIs with NaNA, DSW, UNICEF;  
- desk review |
| 1.5. | To what degree were the project interventions based on a thorough review of cultural and social norms? | - To what extent were the project interventions based on a review of cultural and social norms?  
- Which cultural and social norms (if any) were taken into account? How?  
- Stakeholders’ views and evidences of cultural and social norms integration into the project interventions (description of these cultural and social norms and the way they were integrated) | - KIIs with DSW, NaNa, office of the vice president, DSW, VDC and VSG  
- field observations |

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- Which cultural and social norms (if any) were taken into account? How?  
- Stakeholders’ views and evidences of cultural and social norms integration into the project interventions (description of these cultural and social norms and the way they were integrated) | - KIIs with DSW, NaNa, office of the vice president, DSW, VDC and VSG  
- field observations |
### 2. Impact

| 2.1. | Is there any lasting change that could be identified with regards to the health and nutrition of women and children in the BReST project? |
| - To what extent has the project positively impacted feeding/nutritional habits? |
| - To what extent has the project improved targeted children nutritional status? |
| - To what extent has the project increased utilisation of health services in the targeted populations? |
| - To what extent has the project improved hygiene practices among its targeted population? |

| - Changes in feeding habits (exclusive breastfeeding, dietary diversification, number of meals per day) |
| - Mothers’ knowledge of IYCF |
| - Rates of institutional delivery, Vitamin A service, deworming service |
| - Care-seeking behaviour |
| - Changes in nutritional status: prevalence of acute malnutrition |
| - Changes in hand washing practices, hygiene in preparing food |

| - Quantitative survey among target population and comparison population |
| - Analysis of administrative data |
| - Observation in households and in health facilities |
| - FGDs with beneficiaries and beneficiaries’ spouses |

| - KII with health workers, social workers |
| - Beneficiaries |
| - Comparison group |
| - Beneficiaries’ spouses |
| - Project monitoring data/reports |
| - Health workers |
| - Health facilities |
| - Social workers |
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

### 2.2.
| To what extent has the project contributed to increasing beneficiary households’ resilience to income shocks? | - To what extent has the CT increased the HH productive capacity?  
- To what extent has the CT increased HH savings? | - Utilisation of the CT in income generating activities  
- Utilisation of the CT in saving (bank account, group savings etc) | - Quantitative survey among target population and comparison population  
- FGDs with beneficiaries, beneficiaries’ spouses, VSG and VDS  
- KII with social workers | - Beneficiaries  
- Beneficiaries’ spouses  
- VSG and VDC  
- Social Workers |

### 2.3.
| To what extent has the BReST project increased identity documents in the targeted communities? | - To what extent has the BReST project increased birth registration of children in the targeted communities?  
- To what extent has the BReST project increased beneficiaries’ possession of identity documents?  
- To what extent has the BReST project increased understanding of the importance of owning identity documents among targeted households? | - Birth registration among children in targeted communities  
- Possession identity documents (birth certificate, ID card etc) among beneficiary mothers  
- Mothers’ and fathers’ knowledge of the importance of identity documents | - Quantitative survey among target population and comparison population  
- FGDs with beneficiaries, beneficiaries’ spouses, VSG and VDS  
- KII with Ministry of Health, Regional Health Director and health workers | - Beneficiaries  
- Comparison group  
- Beneficiaries’ spouses  
- Project monitoring data/reports  
- Ministry of Health  
- Health workers |

### 3.
| Effectiveness | Did the project reach its targets in terms of:  
- Number of beneficiaries and coverage (beneficiaries/population in need)  
- Capacity building of national stakeholders?  
- Resilience building? | - Number of beneficiaries  
- Coverage area  
- Evidences on stakeholders’ technical | - Desk review  
- FGDs with beneficiaries, Project Management Team, VSG and VDC | - Beneficiaries  
- Project monitoring data/reports  
- BReST DOA |
| 3.2. & To what extent has the project contributed to better nutrition and care practices in the targeted communities? & To what extent did the project contribute to better nutrition and care practices? & Stakeholders’ views and evidence of achievement of the project outputs and outcomes, and those not achieved and why & Stakeholders’ views on what need to be done in order to improve the project results & - Desk review - FGDs with beneficiaries, beneficiaries’ spouses, VDC, VSG and health workers - KIIs with NaNa, DSW, VDC, VSG, HF & Project monitoring data/reports |
### 3.3.

<table>
<thead>
<tr>
<th>Question</th>
<th>Data Collection Methods</th>
</tr>
</thead>
</table>
| Were the project’s behavioural change and communication strategies      | - To what extent were targeted communities receptive to the project's nutrition education and care education component?  
- Were there difficulties in implementing the behavioural change and communication strategy? What were done to address these difficulties? |  
- Stakeholders' views on the appropriateness of behavioural change strategies and communication  
- Stakeholders' views and evidences of the difficulties encountered and the strategies to address them |
| appropriate to achieve the expected results?                            | - FGDs with beneficiaries, beneficiaries’ spouses, VDC, VSG and health workers  
- KIIs with NaNA, DSW, VDC, VSG, HF |
|                                                                        | - Beneficiaries  
- Beneficiaries’ spouses  
- VCD and VSG  
- NaNA  
- DSW  
- Health workers |

### 3.4.

<table>
<thead>
<tr>
<th>Question</th>
<th>Data Collection Methods</th>
</tr>
</thead>
</table>
| What (if any) are the project unintended and unexpected results?         | - What (if any) are the unintended and unexpected results (positive and negative) that influenced the level of attainment of the project objectives project indicators?  
- Are there any other unexpected results?                               |  
- Observations of positive practices (e.g. Income generating activities)  
- Stakeholders' views and evidence of                                   |
|                                                                        | - Desk review  
- FGDs with beneficiaries; VDC, VSG, health workers  
- Field observations                                                   |
|                                                                        | - Project monitoring data/reports  
- Beneficiaries  
- VCD and VSG  
- NaNA, |
### Efficiency

**4.1.** To what extent were financial resources in the BReST project adequate and used efficiently?

- Was the amount of the cash transfer sufficient in face of the existing needs?
- Was project implementation as cost effective as proposed—planned vs actual?

- Share of household income that was given away as transfer
- Level of discrepancy between planned and utilized financial expenditures.
- Assessment of project in terms of achieved outputs and outcomes vis a vis budget expenditure

- Desk review
- Qualitative data analysis (KII with NaNA, DSW, UNICEF, HF, service provider, VDG; FGDs)

- Any poverty analysis
  - Project DoA
  - NaNA, DSW, UNICEF, HF, service provider, VDG; FGDs

#### Evaluation Framework

- **unexpected and unintended results**
  - KII with NaNA, social workers, Regional Health Director
  - Quantitative analysis of administrative data
  - Social workers
  - Regional Health Director
  - health workers
### 4.2.

<table>
<thead>
<tr>
<th>Question</th>
<th>Evaluation Details</th>
</tr>
</thead>
</table>
| What could have been done to attain the same BReST project objectives but at a lesser cost? |  - Did the way the project was implemented offer the best value for money?  
  - Are there any other options that could have been implemented in order to reduce costs and still reach the project objectives? |
| UNICEF’s views and assessment of evidences regarding the accuracy and completeness of financial information shared |  - Stakeholders’ views of efficient use of allocated resources for results produces  
  - Stakeholders’ views on other options to reduce cost, or to improve results with the same resources |

**KIs with UNICEF, NaNA, DSW, HF**

### 4.3.

- To what extent were the payment operations properly handled?  

Where there strategies to minimize absenteeism?

**KIs with UNICEF, NaNA, DSW, HF**

**UNICEF, NaNA, DSW, HF**
4.4. To what extent were human resources in the BReST project adequate and used efficiently?

- Were the number of implementing staff adequate to deliver the project?
- Were the implementing staff qualified/trained to deliver the project?
- Did the project promote human capacity at the institutional level among major institutional partners (NaNA, DSW)?

- Stakeholders' views and evidences of adequate number of people working for the delivery of services (CT, nutrition education, health screening and services, communication, follow up etc)
- Delivery of trainings across the period of implementation
- Establishment of continuous training to counter potential attrition problems
- Stakeholders' views and evidence of the qualification of staff
- Stakeholders' views on human capacity development in implementing the BReST project

- Desk review
  - KIIs with NaNA, UNICEF, HF, Social workers
  - FGDs with PMT, health workers, VDG; FGDs

- BReST Design and Operational Manual
- BReST Project DoA
- Training curriculum and materials
- NaNA, UNICEF, HF, Social workers
- PMT, health workers, VDG; FGDs
- ROM reviews

5. **Sustainability**
### 5.1. To what extent did the project identify and build an existing national and local civil society and government capacities, structure and mechanisms to avoid dependency on UNICEF funds overtime?

- To what extent did the institutional set-up of the project promote national ownership as well as the continuation of activities by national entities after the project completion?
- How much does this set-up rely on existing institutions/mechanisms at the local and national level?
- Are the capacities of these local and national structures/mechanisms built in order to ensure their effective and efficient support to the project?

### 5.2. To what extent were the project achievements sustained and for the most recent ones how will they be sustained when external support ends?

- Are mothers in the project using improved feeding practices and for how long?
- Does the project increase women/mothers' use of health facilities?
- Stakeholders' views on how the project achievements will be sustained when external support ends

**Data Sources:**
- Desk review
- KIIs with NaNa, UNICEF, the WB, DSW, VDC and VSG
- DoA
- ROM reviews
- BRReST design and operational manual
What has been done and what can stakeholders do more to ensure that project achievements are kept and improved further over time?

- Is the government willing/able to pursue the project after the end of external supports?
- Are there any actions taken by national and local stakeholders to continue implementing the project after its closure?
- Do implementing bodies (NaNa, health facilities, ...) have enough capacity to continue the project without external support?
- What do stakeholders need in order to ensure that project achievements are kept and improved over time?

- Political commitment
- Existence of a budget line in the government budget
- Stakeholders' views and evidence of implementing bodies' capacity
- Stakeholders' views and evidence on what has been done to ensure that project achievements are kept and improved further over time?
- Stakeholders' view on what is needed in order to ensure that project achievements are kept and improved over time?

- Desk review
  - KIs with NaNa, DSW, UNICEF, VDG, HF

- National Development Plan
- National Social Protection Policy
- NaNa, DSW, UNICEF, VDG, HF
- ROM reviews

6. Gender, Equity and Human rights
<table>
<thead>
<tr>
<th>6.1.</th>
<th><strong>To what extent were Gender, Human Rights and Equity principles duly integrated in the design, delivery and monitoring of the project?</strong></th>
</tr>
</thead>
</table>
| - To what extent did the project take into account gender aspects in its design, delivery and monitoring?  
- To what extent did the project take specific actions in order to ensure the participation of vulnerable/excluded households?  
- To what extent did the project have any safeguards to ensure that the basic rights of its beneficiaries (including women and children) are respected, and no one is discriminated because of gender, ethnicity or religion?  
- To what extent did the project advance the right of the beneficiaries? | - Diversity of participant in terms of ethnicity and level of well-being  
- Types of complaints/appeals  
- Stakeholders' views and evidences of the project compliance with national and international obligations towards women and children  
- Stakeholders' views and evidences of what prevent vulnerable and excluded households from having a good nutritional status and what is done to address that |
<table>
<thead>
<tr>
<th>6.2.</th>
<th><strong>To what extent did the BReST project tackle the barriers that prevent girls' and women's access to the services that it made available in the targeted communities?</strong></th>
</tr>
</thead>
</table>
| - What barriers (if any) exist that impede the girl's and women's expected level of access to the project?  
- What actions (if any) were taken within the scope of this project to tackle the identified barriers? | - % of women and girls in the project  
- Stakeholders' views on the barriers that prevent girls and women to access the services and what was made to address them |
6.3. What unexpected effects, positive or negative can they be seen in relation to the issue of gender equality? - Were there unexpected effects on Gender during the implementation of the Project

Note: KII: key informants’ interview; NaNA: National nutrition agency; DSW: Department of social welfare; MoHSW: Ministry of Health and Social Welfare; HF: Health facility; FGD: focus group discussion; DoA: Description of action; VDG: Village development group
Annex 5. A cross-cutting approach for the evaluation

The evaluation methodology is anchored in a **cross-cutting approach** encompassing: (i) the equity-based and human-rights approach, (ii) the life cycle approach, (iii) the economic approach, and (iv) the participatory approach.

The **equity-based and human-rights approach** identifies disparities (according to the area and region of residence, gender, socio-economic status, etc.) and analyses the causes of such inequalities and major bottlenecks to their resolution. This approach allows for analysis at the political, legal, budgetary and social level, as well as at the levels of the supply of quality services and the demand for them. The results of such an analysis make it possible to define areas of action for the better consideration of disadvantaged groups, especially children and women, at a political and strategic level. Figure 23 presents the conceptual framework for the equity-based approach.

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**Figure 24. Conceptual framework for the equity-based approach**

Source: UNICEF 2014, Formative Evaluation of UNICEF’s Monitoring Results for Equity System (MoRES)

The **human rights-based approach**, particularly within the framework of the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), aims at securing the rights of ALL, especially of the most vulnerable groups in a society. The basic social rights of children, often already guaranteed by laws or conventions, could be summarised as follows:

1. The right of children to survive (access to basic health services, adequate and nutritious food, healthy dwellings, clean water sources, etc.);
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

2. The right of children to grow and develop in a healthy way;
3. The right of children to be educated commensurate with their personal abilities and preferences;
4. The right of children to participate in society;
5. The right of children for protection.

As part of this evaluation, the dimensions related to survival conditions of children during the first stages of life (access to basic health services, adequate and nutritious food) will be analyzed.

The life-cycle approach recognises that children’s needs vary according to their age. This analysis will therefore ensure to highlight vulnerabilities specific to each age group. The different life cycles are illustrated in Figure 24. This approach incorporates differences in needs, deprivation and vulnerabilities of children during infancy, early childhood, childhood and adolescence.

In relation to a life-cycle approach, this evaluation focuses on the scope of intervention of BReST, which covers the nutritional dimension and health needs of infants from the conception phase to their second year of life, corresponding, therefore to pregnancy, neonatal and infancy stages.

Figure 25. Main stages of an individual's life-cycle

Source: Claeson & Waldman, 2000 in De Neubourg et al. (2013)

The economic approach ensures the development and proposal of programmatic solutions embedded into the economic and political reality prevailing in the country. The analysis includes global issues that may have impact on the Gambia’s development and on Government intervention. As such, guaranteeing survival, development, participation and protection as investment in human capital for increased productivity and economic development will be hypothesized and supported by hard evidence.
The **participatory approach** enables the active involvement of stakeholders to reflect the perceptions of each of the stakeholders involved in the implementation of the project. In addition, their active participation is needed to ensure the local ownership of the analysis and joint identification of national priorities and context-specific solutions. Beyond the reflection on the project implementation, the evaluation team made use of the participatory approach to explore lessons learned and perceptions on areas of improvement which are crucial insights to build relevant and actionable recommendations.

The data collection methods to be applied are summarised in the following sub-chapters and categorised under the broader qualitative and quantitative methods headings.
Annex 6. Qualitative methods (inception stage)

1. The documentary review

The documentary review relies on the analysis of key background documents that contextualize the project as well as on project documents that help identify:

iv) the intervention context and the programmatic objectives;
v) the characteristics of the target population and its environment;
vii) the operational characteristics of the project (targeting, design, operations and procedures).

In addition to these aspects, the desk review has also allowed to understand the emergence of the project in its synergies with the World Bank-led project and the national institutional framework.

At the launch of the evaluation, UNICEF has shared with the evaluating team, the framework documentation of the BReST project for a comprehensive analysis. The following documents were studied during the inception phase and constitute, to date, the core of documentary corpus:

- BReST High-level Design and Operational Manual (Ministry of Health and Social Welfare & EPRI, 2017);
- BReST Project Description of Action (European Union, 2016);
- BReST Project Results Oriented Monitoring (ROM) Report (European Union, 2018)
- BReST Project Results Oriented Monitoring (ROM) Questions (European Union, 2018)
- The Gambia National Health Policy (2012-2020)

The literature review is a continuous process and, as such, the team of evaluators requested the incorporation of specific documents to deepen the analysis at each stage of the evaluation. During the data collection phase in Banjul and BreST regions (Mission 1, October 28th to November 1st) the evaluation team identified, gathered and reviewed the documents made available by UNICEF and the project’s implementing agency here NaNA, including progress reports and field reports by social workers.

The desk review also examined contextual information on the nutritional health of women and children as identified by the World Bank’s MCHNRP project during the mid-term evaluation. In the absence of a baseline for the BReST project, these data provided a

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foundation of essential information for understanding the vulnerability of populations covered by BreST.

2. **Preliminary interviews with Key Informants at the national and regional level**

The search for key informants to participate in the interviews was guided by UNICEF Gambia and supplemented by specific requests from the evaluation team. The criteria used to retain the participants are the following:

i) direct involvement in project implementation (design and management);

(ii) indirect participation, for example in the case of programs acting in synergy with BReST;

(iii) common interests on the overall objectives;

Key informant interviews at the national level were conducted (remotely) during the inception phase in order to contextualize the project history and the details and adjustments in the project implementation in its different components.

During this first round of interviews, the evaluators tried to identify the main successes, challenges and barriers to the implementation of BReST. They also tried to grasp the main lessons learned from the experience of setting up the project.

During the inception phase, the evaluators conducted the interviews with the focal points of the following institutions:

- UNICEF, Social Protection Officer (September 9th);
- Government of the Gambia, Department of Social Welfare, Senior Welfare Officer (September 13th and September 16th);
- Government of the Gambia, National Nutrition Agency (NaNA) Acting Deputy Executive Director (September 18th);
- Payment Institution, NACCUG – Finance and Admin Officer (September 12th);
- The World Bank Focal Point for Maternal and Child Nutrition and Health Results Project (September 20th)

Previous interviews were complemented by in-depth interviews during the first field mission (October 28th to November 1st) with other institutional actors engaged in BReST. As such, the evaluation team carried out interviews with:

- the NaNA IT team (October 28th, Banjul);
- the PMT within the NaNA (November 1st, in Banjul)
- the representatives of the EU Delegation in The Gambia (October 28th, Banjul),
- the focal point at the Ministry of Health (October 28th, Banjul)
- representatives of parliament (October 28th, Banjul)
The purpose of these interviews was to learn more about the project's experience and ideas for improving practices to document lessons learned during the implementation of BReST. In addition, these exchanges provided the evaluation team with an in-depth understanding of concrete interventions and dialogue between institutional partners (e.g. between NaNA and the Ministry of Health, or between the BReST Project and the MCNHRP).

3. **Focus group discussions and Key informant interviews at regional and local level**

The purpose of the qualitative component is to gather information from the project stakeholders and beneficiaries to understand their experience in implementing the project, thus meeting the general objective of the evaluation to learn from the current experience and capitalize for future projects.

Beyond interviews with project stakeholders (as per description in the previous section), the qualitative component aims to collect information on the beneficiaries’ experience along with knowledge from service providers that interact directly with beneficiaries (here, social workers and health and nutrition officers).

**Individual interviews at regional level**

The following counter-parts were considered for the individual interviews, following discussions with UNICEF Gambia:

**NaNA officers at regional level:** NaNA officers at the regional level are the relays of the implementation agency for each province. During the data collection process, NaNA focal points at the regional level were considered to gather information on the implementation experience in each of the three regions.

**Social Workers:** Because of their central role in the interaction with recipients, social workers are key informants to assess the project functioning. As per the organization set up for BReST, a social worker was assigned to each region to perform the monitor the beneficiary. For this reason, the evaluation team conducted one interview per region with each of the three project social workers.

**Focus group discussions at local level**

The following participants were considered for the focus groups discussions, following discussions with UNICEF Gambia:
Village Development Committees (VDC) and Village Support Groups (VSG): The evaluation team understands that VDCs provide a platform for services provision at the local level, which is decided by the community members themselves after deliberation. As such, it was decided to conduct 7 focus groups with members of the village committees, to better assess the needs of each community. The selection of communities was proposed by the evaluation team local partner and approved by UNICEF prior to the first mission. 7 focus group discussions were conducted with VSGs, whose role in the project is to disseminate health messages and accompany good health and nutrition practices. These FDGs were essential to understand the penetration of BReST at the level of the community, and the ownership at the level of the members involved in the implementation of BReST but also the MCNHRP.

Health and nutrition workers: Because of their direct contact with BReST beneficiaries, and therefore their knowledge of the health situation of mothers and their children, the evaluation team prioritized focus groups with these actors to get a common understanding on the health issues observed in the health facilities and know more about their experience in interacting with beneficiaries within health centers. A total of six focus groups with the medical staff were carried out during the first field mission.

Beneficiaries: The evaluation team proposes to organize one focus group per payment site, i.e. 10 focus groups in total, with women who are recipients of the social transfer project, during the second field mission. The focus groups will comprise no more than twelve participants. The selection of participants will be guided by the local community representatives, in particular VDCs and VSGs, to ensure appropriate and non-intrusive communication with beneficiaries. FGDs will be conducted in the bantaba, which is a place where villagers meet to discuss collective matters. Through the FDGs, the team of evaluators expects to better understand the adoption or barriers to adoption of the practices promoted by the project and the perception of individuals on topics related to nutrition and health, domestic economy and gender relations within the household.

Focus groups with beneficiaries’ partners/ spouses: The evaluation team proposes to complete the information gathered via women’s focus groups with 10 focus groups with men (i.e. 1 group per payment site). These complementary groups will allow to deepen the understanding of gender impact and gender relations within the household.

The set of data collection instruments is provided in Annex 4 to 10.

4. Field Observations

Observing practices is a key triangulation tool to counterbalance data from testimonials or statements. As part of the evaluation process, the team used observation in a non-obstructive manner in the following situations:
During stakeholder interviews at national level, within the implementing agency, the evaluation team observed the monitoring done in SCOPE on the basis of a demonstration done by the information technology (IT) team; 

At the health facilities where the majority of services are provided to the BreST beneficiaries the evaluation team observed the records held by the personnel; 

At the local level, in the beneficiaries’ household, the evaluation team foresees to carry out observations during the quantitative survey. In this case observations are systematized in the questionnaire instrument.

Regarding the observations at the local level, the evaluation team prepared and trained the enumerators to integrate non-obstructive observations during the quantitative data collection phase. These observations relate mainly to hygiene practices.

5. **Limitations and challenges in the implementation of the qualitative component**

**Absence of observation of key interactions such as activities during Payment days:**

Since the evaluation started after the last payment of BreST was completed, the evaluation team could not observe the activities during a standard payment day with its different components (payment delivery, raising beneficiaries’ awareness on health and nutrition practices, complaints treatment, collection and process of monitoring health indicators and monitoring of sensitive cases by social workers). These observations would have made it possible to refine the analysis of the procedures and to allow a more exhaustive evaluation of the capacities of the agents to deliver the services of BreST. Also, it would have allowed for a better assessment of the demand (attendance, problems encountered in the interaction between recipients and payment organization, etc.) In order to retrace part of what happens in a regular payment day, in addition to asking for a description of the latter to the stakeholders involved, the team of evaluators analyzed the books held within the health facilities and the reports drafted by social workers. In addition, the team analyzed the payment spreadsheets facilitated by the payment NGO.

**Recall bias:**

Given that part of the interview guide asked the respondents to reflect on their past experiences, it is possible that the interviewees were led to report the experiences with a certain degree of inaccuracy, or that they chose or preferred to recall certain information instead of others. To overcome this bias, the multiplication of interactions with agents at the regional level, then with the implementing agency at the national level (NaNA) has made it possible to point out possible problems, dysfunctions or conversely, positive points that would not have been mentioned.
**Perceptions bias:**

Focus groups with the beneficiaries as a qualitative method will capture recipients’ perception of the project, and in doing so, the evaluation team will be able to draw a general assessment of the impact. However, the actual impact can only be established in light of measurable indicators. This is why, the consultants expect that the quantitative component will enrich and complete the qualitative data.

**Causality determination:**

The BReST project is unanimously perceived positively by all the stakeholders met so far. This is obviously illustrative of a project that has worked well according to the set of testimonies collected under the qualitative component (with the exception of testimonials from beneficiaries who have not yet been met). However, since its design, the BReST Project has been designed in conjunction with other projects. From a programmatic point of view, these effects show a good cross-sectoral dynamic. However, from a methodological point of view this poses a major challenge to the evaluation, which is that of isolating the effects of BReST with respect to the effects of other projects such as MCNHRP. In order to overcome this challenge, the quantitative component has been designed to discern the effects of BReST in contrast to the effects of other projects. In particular, the evaluation was designed to capture only the value added by the BReST project to the MCNHRP as described in the subsection on quantitative methods.

**Language and cultural barriers:**

Since focus groups with the community have been conducted in the local language and facilitated by one of the local evaluators, the translation may have induced data accuracy gaps. In order to overcome this problem, local evaluation team, proficient in local languages, were coached for a day in facilitating focus groups, commenting on the content of the guides and simplifying questions when needed. In the field, teams of international evaluators formulated the questions in English, leaving local evaluators to interact with communities and reinterpret the content at each iteration.
Annex 7. Interview guide: NaNA regional level

Semi-structured interview guide for interviews with the National Nutrition Agency (NaNA) at regional level

Date:

Location:

Interlocutor:

Moderator(s):

Duration of interview: hours minutes

Notes:

Introduction and consent

Interviewer: Good morning/afternoon, Sir/Madam _________. Thank you very much for giving us the opportunity to interview you. My name is ___________, and together with my colleague ________ we work for Social Policy Research Institute.

As you might have been informed when this interview was scheduled, we are independent evaluators that are currently looking at the BReST Cash Transfer Project to better understand what worked and what did not during its implementation. This would include success, progress, challenges and barriers in the implementation of the project.

To gain an understanding on the issue we are interviewing different institutional representatives at the national, regional and local level along with local implementing partners including NGOS, local community leaders, household members and, direct beneficiaries of the BReST project, (that is, mothers with children under two).

Today I would like to discuss with you about different aspects related to the implementation of the BReST project including informing and outreach activities, identification and verification of beneficiaries, disbursement of payments, as well as the key challenges that you face(d) when implementing these activities.

This interview will last between 1-1.5 hours and your contribution will be treated with confidentiality, it will not be shared with other parties, and will only serve to inform the government about the implementation of the program as it reaches its end. Shall we start? [Note for the interviewer: Do ask for oral consent]
General Questions

Q1. I would like to start the interview with a brief introduction. Could you please tell me for how long you have been working in the BReST project and what have been your roles in the various phases of the project?

Q2. Do you participate in the Project Management Team (PMT)? What is your role in the PMT?

Q3. Have you been involved in the design or planning phase of the BReST project? If yes, had you at that time identified any relevant challenges for the implementation of the project? If yes, could you please describe them? What did you do to address these challenges?

   Q3.a. Was the PMT made aware of your concerns? Were these challenges addressed before and during the implementation of the project? If yes, how?

[Note for the interviewer: Probe on the nature of the identified challenges. Where they at the behavioural or cultural levels?]

Q4. Could you please walk me through the support activities provided by your organization to the BReST Project in terms of administration and implementation? I am interested to learn from you about the 5 steps of the BReST Social Transfer delivery process: (1) mobilization and sensitization; (2) identification; (3) verification; (4) registration of the beneficiaries; and (5) disbursement of payments.

[Note for the interviewer: Ask the interviewee(s) to elaborate on each of the five stages. Make sure you cover all the stages and refer to each one of them separately if the interviewee skips anything]

Q5. Do you also participate in the implementation of the Maternal and Child Nutrition and Health Results Project? If yes, what kind of dialogue or coordination process exists between these two projects at your level?

[Note for the interviewer: If they respond NO, briefly describe the project to ensure the interviewee(s) exactly knows what is being referred to (describing it as a World Bank project could help)]

Capacity Development

Q6. In the course of the project implementation, did you receive any training to help you achieve the project’s objectives? If yes, what type of training did you receive? Are there other trainings you wish you had received? If yes, which ones?

Mobilization and sensitization activities

Q7. Did you carry out the information and outreach activities of the BReST project? If yes:

   Q7.a. Could you please describe the information and outreach activities you carried out? At which stages of the project did you conduct these activities, what type of information do you typically provide, through what channels/means?

   Q7.b. Who are the targets of the information campaigns and the outreach activities?

[Note for the interviewer: clarify if the activities are only targeted to beneficiaries, or also other community members; is there specific activities targeted to men in the families/communities?]

   Q7.c. In your opinion, what is the impact of these activities on mother’s knowledge on IYCF practices, and on demand and health service utilization?
Q7.d. Which activities do you think have proven more successful in reaching the potential beneficiaries? Why? What else may need to be done to improve community/parents’ awareness and how?

Q8. Are other institutions/stakeholders involved in mobilization and sensitization activities of the BReST project? If yes, could you briefly describe the activities and the institutions involved?

Q9. What were the main challenges that you faced in reaching potential beneficiaries to inform them about the program, its eligibility criteria/requirements, and how they can realize their rights?

Q10. Are there differences in the challenges faced when reaching out to women that gave birth in the health facilities and those who gave birth outside the health facilities?

Eligibility Criteria and Registration Process

Q11. Could you please list the eligibility criteria for the BReST Social transfer benefit?

Q12. Could you please walk me through the process starting when the mothers (or their proxies) register to the project to the moment when a decision is made about their eligibility to enroll in the project?

[Note for the interviewer: Also enquire about the following: (1) Is there a pre-identification process for women who gave birth at the HF program? (2) For other cases, who usually applies/Who can register? (3) Does identification happen during the payment days? (4) What documents do applicants have to present? (5) What documents do they most commonly present (especially focus on understanding whether the applicants tend to bring documents that are different from what is officially required for registration)?]

Q13. What type of information should usually be provided to applicants when they register for the BReST project?

[Note for the interviewer: Probe with the following: (1) After how long (days or in how many weeks or months) applicants will be informed about their application status; (2) How they will be informed; (3) The amount of the transfer, how often it is provided, where it can be obtained; (4) Their other rights and obligations, such as informing whether the beneficiary or child is deceased, where they can complain if their application is rejected, etc.]

Q14. Could you describe the identification and verification process for women having delivered in a health facility?

Q15. Could you now describe the identification and verification process for women who have not delivered in a health facility?

Q16. What are the main challenges in the identification of potential beneficiaries?

   Q16.a. What issues do you face with verifying the documentation that the applicants provide?

   Q16.b. How are these challenges usually addressed?

   Q16.c. How are these challenges different for women having delivered in a health facility and for those who haven’t?

Q17. Based on your experience, what are the main challenges that potential beneficiaries face when applying for the program and proving their eligibility?
Q17.a. How are these challenges different for women having delivered in a health facility and for those who haven’t?

Q18. How does the BReST Project make the decision on the eligibility of applications? How long does it usually take to make the decision?

Q19. Is there a legal time-frame within which you are obliged to inform the beneficiaries about their application status? If yes, how long is it? [Number of days/weeks/months]

Q20. How do you typically inform the applicants that they are eligible for the BReST Social Transfer? Could you describe this activity?

Q21. How do you usually inform the rejected applicants about their status? Could you please walk me through the stages of this process?

**Appeals/complaint mechanism**

Q22. Is there an appeals/complaint mechanism/procedure for rejected applications? Could you please describe each of its steps?

[Note for the interviewer: Make sure to cover the following: (1) When are the applicants informed about the right to complaint/appeal; (2) What is the procedure to file a complaint; (3) Who reviews the complaint/appeal; and (4) Timeframe for reviewing the complaint/appeal by the social worker; (5) how and where the complaints are documented and stored; (6) is there a database of filed complaints]

Q23. Is there a complaint mechanism/procedure for beneficiaries? Could you describe each of its steps?

[Note for the interviewer: Also probe: (1) Are the beneficiaries informed about the complaint procedure; (2) What is the procedure to file a complaint; (3) how and where the complaints are documented and stored; (4) is there a database of filed complaints; (5) what are the main issues reported]

**Disbursement/payment process**

Q24. Could you please walk me through the activity of payment to beneficiaries?

[Note for the interviewer: Make sure to cover the following aspects: (1) Where are the payments made?; (2) How often are the money paid out and for how many days during a period (e.g. if the payments are made in April, how many days during April are the money paid out)?; (3) How common are the cases that eligible beneficiaries do not/are not able to withdraw the social transfer?]

Q25. What were the main challenges in disbursing the benefits?

[Note for the interviewer: probe if there were (1) security concerns; (2) fraud cases; (3) geographical challenges; (4) issues with transportation and other infrastructure]

**Data management**

Q26. Could you explain to me how the beneficiary data is managed? What is the system used? How (and with what technology) was the information collected and stored?

Q26.a. Where is the database stored, and who have access to the database (at national, regional and HF levels)?

Q26.b. Did you experience challenges in operating/using the system?
Perception of impacts and way forward

Q27. What do you think are the main impacts of the project, in short term and long term?

[Note for the interviewer: the perceived impacts can be positive or negative]

Q28. What do you think could be improved in the project? If this project is to be replicated in the future, what would you recommend to change/improve?

Closing the interview Interviewer thanks the participant(s) for her/his time and their contributions to the discussion.
Annex 8. Interview guide: National stakeholders

Semi-structured interview guide for interviews with institutional representatives at central level

Date:

Location:

Interlocutor:

Moderator(s):

Duration of interview:                    hours                      minutes

Notes:

**Introduction and consent**

*Interviewer: Good morning/afternoon, Sir/Madam _________. Thank you very much for giving us the opportunity to interview you. My name is ___________, and together with my colleague _________ we work for Social Policy Research Institute.*

As you might have been informed when this interview was scheduled, we are independent evaluators that are currently looking at the BReST Cash Transfer Project to better understand what worked and what did not during its implementation. This would include success, progress, challenges and barriers in the implementation of the project.

To gain an understanding on the issue we are interviewing different institutional representatives at the national, regional and local level along with local implementing partners including NGOS, local community leaders, household members and, direct beneficiaries of the BReST project, (that is, mothers with children under two).

Today I would like to discuss with you about different aspects related to the implementation of the BReST project including informing and outreach activities, identification and verification of beneficiaries, disbursement of payments, as well as the key challenges that you face(d) when implementing these activities.

This interview will last between 1-1.5 hours and your contribution will be treated with confidentiality, it will not be shared with other parties, and will only serve to inform the government about the implementation of the program as it reaches its end. Shall we start? [Note for the interviewer: Do ask for oral consent]
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

General Questions

Q1. I would like to start the interview with a brief introduction. Could you please tell me for how long you have been working in the BReST project, what have been your roles in the various phases of the project, and when has your organization started implementing the BReST project?

Q2. Do you participate in the Project Steering Committee (PSC) or Project Management Team (PMT)? What is your role in the PSC/PMT?

Q3. Have you been involved in the design or planning phase of the BReST project? If yes, had you at that time identified any relevant challenges for the implementation of the project? If yes, could you please describe them? What did you do to address these challenges?

   Q3.a. Was the PMT made aware of your concerns? Were these challenges addressed before and during the implementation of the project? If yes, how?

[Note for the interviewer: Probe on the nature of the identified challenges. Where they at the behavioural or cultural levels?]

Q4. Could you please walk me through the support activities provided by your organization to the BReST Project in terms of administration and implementation? I am interested to learn from you about the 5 steps of the BReST Social Transfer delivery process: (1) mobilization and sensitization; (2) identification; (3) verification; (4) registration of the beneficiaries; and (5) disbursement of payments.

[Note for the interviewer: Ask the interviewee(s) to elaborate on each of the five stages. Make sure you cover all the stages and refer to each one of them separately if the interviewee skips anything]

Q5. Did you also participate in the implementation of the Maternal and Child Nutrition and Health Results Project? If yes, what kind of dialogue or coordination process exists between these two projects at your level?

[Note for the interviewer: If they respond NO, briefly describe the project to ensure the interviewee(s) exactly knows what is being referred to (describing it as a World Bank project could help)]

Capacity Development

Q6. In the course of the project implementation, did you receive any training to help you achieve the project’s objectives? If yes, what type of training did you receive? Are there other trainings you wish you had received? If yes, which ones?

Mobilization and sensitization activities

Q7. Did you carry out the information and outreach activities of the BReST project? If yes:

   Q7.a. could you please describe the information and outreach activities you carried out? At which stages of the project did you conduct these activities, what type of information do you typically provide, through what channels/means?

   Q7.b. Who are the targets of the information campaigns and the outreach activities?

[Note for the interviewer: clarify if the activities are only targeted to beneficiaries, or also community members or other groups; is there specific activities targeted to men in the families/communities?]
Q7.c. In your opinion, what is the impact of these activities on mother’s knowledge on IYCF practices, and on demand and health service utilization?

Q7.d. Which activities do you think have proven more successful in reaching the potential beneficiaries? Why? What else may need to be done to improve community/parents’ awareness and how?

Q8. Are other institutions/stakeholders involved in mobilization and sensitization activities of the BReST project? If yes, could you briefly describe the activities and the institutions involved?

Q9. What were the main challenges that you faced in reaching lactating women with children under the age of 24 months to inform them about the program, its eligibility criteria/requirements, and how they can realize their rights?

Q10. Are there differences in the challenges faced when to women that gave birth in the health facilities and those who gave birth outside the health facilities?

Eligibility Criteria and Registration Process

Q11. Could you please list the eligibility criteria for the BReST beneficiaries?

Q12. Could you please walk me through the process starting when the women with children under the age of 24 months or their proxies register to the project to the moment when a decision is made about their eligibility to receive the social transfer?

[Note for the interviewer: Also enquire about the following: (1) Is there a pre-identification process for women who gave birth at the HF program? (2) For other cases, who usually applies/Who can register? (3) Does identification happen during the payment days? (4) What documents do applicants have to present? (5) What documents do they most commonly present (especially focus on understanding whether the applicants tend to bring documents that are different from what is officially required for registration)?]

Q13. What type of information was provided to applicants when they register for the BReST project?

[Note for the interviewer: Probe with the following: (1) After how long (days or in how many weeks or months) applicants will be informed about their application status; (2) How they will be informed; (3) The amount of the transfer, how often it is provided, where it can be obtained; (4) Their other rights and obligations, such as informing whether the beneficiary or child is deceased, where they can complain if their application is rejected, etc. ?]

Q14. Could you now please walk me through the identification and verification process for women having delivered in a health facility?

Q15. Could you now please walk me through the identification and verification process for women who have not delivered in a health facility?

Q16. What are the main challenges in the identification of potential beneficiaries? What issues are faced when verifying the documentation that the applicants typically provide? How are these challenges usually addressed? How are these challenges different for women having delivered in a health facility and for those who haven’t?
Q17. Based on your experience, what are the main challenges that potential beneficiaries face with applying for the program and proving their eligibility? How are these challenges different for women having delivered in a health facility and for those who haven’t?

Q18. How does the BReST Project make the decision on the eligibility of applications? How long does it usually take to make the decision?

Q19. Is there a legal time-frame within which you are obliged to inform the beneficiaries about their application status? If yes, how long is it? [Number of days/weeks/months]

Q20. How do you typically inform the applicants that they are eligible for the BReST Social Transfer? Could you please walk me through this activity?

Q21. How do you usually inform the rejected applicants about their status? Could you please walk me through the stages of this process?

**Appeals/complaint mechanism**

Q22. Is there an appeals/complaint mechanism/procedure for rejected applications? Could you please walk me through each of its steps?

[Note for the interviewer: Make sure to cover the following: (1) When are the applicants informed about the right to complaint/appeal; (2) What is the procedure to file a complaint; (3) Who reviews the complaint/appeal; and (4) Timeframe for reviewing the complaint/appeal by the social worker; (5) how and where the complaints are documented and stored; (6) is there a database of filed complaints]

Q23. Is there a complaint mechanism/procedure for recipients? Could you please walk me through each of its steps?

[Note for the interviewer: Also probe: (1) Are the recipients informed about the complaint procedure; (2) What is the procedure to file a complaint; (3) how and where the complaints are documented and stored; (4) is there a database of filed complaints; (5) what are the main issues reported]

**Disbursement/payment process**

Q24. Could you please walk me through the activity of disbursement/payment of social transfers?

[Note for the interviewer: Make sure to cover the following aspects: (1) Where are the payments made?; (2) How often are the social transfers paid out and for how many days during a period (e.g. if the payments are made in April, how many days during April are the social transfers paid out)?; (3) How common are the cases that eligible beneficiaries do no/are not able to withdraw the social transfer?)

Q25. What were the main challenges in disbursing the benefits?

[Note for the interviewer: probe if there were (1) security concerns; (2) fraud cases; (3) geographical challenges; (4) issues with transportation and other infrastructure]

**Perception of impacts and way forward**

Q26. What do you think are the main impacts of the project, in short term and long term?

Q26.a. In your view, are there any unintended (positive or negative) impact of the BReST project
[Note for the interviewer: the perceived impacts can be positive or negative]

Q27. What do you think could be improved in the project? If this project is to be replicated in the future, what would you recommend to change/improve?

Q28. Could you tell us if the BReST project was part of the National Development Plan, and how? Are there prospects for institutionalizing the program after this first experience? How could this be done?

Closing the interview Interviewer thanks the participant(s) for her/his time and their contributions to the discussion.
Annex 9. Interview guide: Social workers

Semi-structured interview guide for interviews with social workers

Date:

Location:

Interlocutor:

Duration of interview:             hours                      minutes

Notes:

Introduction and consent

Interviewer: Good morning/afternoon, Sir/Madam _________. Thank you very much for giving us the opportunity to interview you. My name is ___________, and together with my colleague ________ we work for Social Policy Research Institute.

As you might have been informed when this interview was scheduled, we are independent evaluators that are currently looking at the BReST Cash Transfer Project to better understand what worked and what did not during its implementation. This would include success, progress, challenges and barriers in the implementation of the project.

To gain an understanding on these issues we are interviewing different institutional representatives at the national, regional and local level along with local implementing partners including NGOs, local community leaders, household members and, direct beneficiaries of the BReST project, (that is, mothers with children under two).

Today I would like to discuss with you about different aspects related to the administration (operations) of the BReST project including informing and outreach activities, identification and verification of beneficiaries, disbursement of payments, as well as the key challenges that you face(d) when implementing these activities.

This interview will last between 1-1.5 hours and your contribution will be treated with confidentiality, it will not be shared with other parties, and will only serve to inform the government about the implementation of the program as it reaches its end. Shall we start? [Note to interviewer: Do ask for oral consent]
Introduction

Q1. I would like to start the interview with a brief introduction. Could you please tell me for how long you have been working in the BReST project and what have been your roles in the various phases of the project?

Q2. Who are the beneficiaries you serve in the BReST project? Which area(s) do you cover?

Q3. Have you been involved in the design or planning phase of the BReST project? If yes, had you at that time identified any relevant challenges for the implementation of the project? If yes, could you please describe them? What did you do to address these challengers? No.

Q3.a. Was the PMT made aware of your concerns? Were these challenges addressed before and during the implementation of the project? If yes, how?

[Note for the interviewer: Probe on the nature of the identified challenges. Where they at the behavioural or cultural levels?]

Q4. Could you please describe the type of activities that you carry out to reach the expected project beneficiaries? How do you interact with them?

[Note for the interviewer: Probe on the different activities constituting the mandate of Social Workers, i.e. operational aspects other than mobilisation, sensitization and education: (1) identification and registration of beneficiaries; (2) supervision of cash payments; (3) oversight of investigation processes on project misconduct; (4) complaints filing; (5) others.]

Q5. Did you also participate in the implementation of the Maternal and Child Nutrition and Health Results Project? If yes, what kind of dialogue or coordination process exist between these two projects at your level?

[Note for the interviewer: If they respond NO, briefly describe the project (describing it as a World Bank project could help) to ensure the interviewee(s) exactly knows what is being referred to]

Capacity Development

Q6. In the course of the project implementation, did you receive any training? If yes, what type of training did you receive? Are there other trainings you wish you had received? If yes, which ones?

Mobilization and sensitization activities

Q7. Did you carry out the information and outreach activities of the BReST project? If yes:

Q7.a. Could you describe the information and outreach activities you carried out? At which stages of the project did you conduct these activities, what type of information do you typically provide, through what channels/means?

Q7.b. Who are the targets of the information and the outreach activities?

[Note for the interviewer: clarify if the activities are only targeted to project beneficiaries, or also other community members; are there specific activities targeted to men?]

Q7.c. In your opinion, what is the impact of these activities on mother’s knowledge on IYCF practices, and on demand and health service utilization?
Q7.d. Which activities do you think have proven more successful in reaching the potential beneficiaries? Why? What else may need to be done to improve community/parents’ awareness and how?

Q8. What were the main challenges that you faced in reaching potential beneficiaries to inform them about the BReST project, its eligibility criteria/requirements, and how they can realize their rights?

Q8.a. What are the differences in challenges between reaching out to women that gave birth in the health facilities and those who didn’t?

Eligibility and enrolment in the BReST project

Q9. Could you please list the eligibility criteria for the BReST Social transfer benefit?

Q10. Could you please walk me through the process starting when the mothers (or their proxies) register to the project to the moment a decision is made about their eligibility to enrol in the project?

[Note for the interviewer: Also enquire about the following: (1) Is there a pre-identification process for women who gave birth at the HF program? (2) For other cases, who usually applies/Who can register? (3) Does identification happen during the payment days? (4) What documents do applicants have to present? (5) What documents do they most commonly present (especially focus on understanding whether the applicants tend to bring documents that are different from what is officially required for registration)?]

Q11. What type of information do you usually provide to applicants when they register for the BReST project?

[Note for the interviewer: Probe with the following: (1) After how long (in days/weeks/months) applicants will be informed about their application status; (2) How they will be informed; (3) The amount of the transfer, how often it is provided, where it can be obtained; (4) Their other rights and obligations, such as informing whether the beneficiary or child is deceased; (5) where they can complain if their application is rejected, etc.]

Q12. Could you describe the identification and verification process for women having delivered in a health facility?

Q13. Could you describe the identification and verification process for women who have not delivered in a health facility?

Q14. What are the main challenges that you and your team face with the identification of potential beneficiaries?

Q14.a. What issues do you face with verifying the documentation that the applicants provide?

Q14.b. How do you usually cope with these challenges?

Q14.c. How are these challenges different for women having delivered in a health facility and for those who haven’t?

Q15. Based on your experience, what are the main challenges that beneficiaries face when applying for the program and proving their eligibility?
Q15.a. How are these challenges different for women having delivered in a health facility and for those who haven’t?

Q16. How does the BReST Project make the decision on the eligibility of applicants? How long does it usually take to make the decision?

Q17. Is there a legal time-frame within which you are obliged to inform the beneficiaries about their application status? If yes, how long is it? [Number of days/weeks/months]

Q18. How do you typically inform the applicants that they are eligible for the BReST Social Transfer?

Q19. How do you usually inform the rejected applicants about their status?

Complaint/Appeals Mechanism

Q20. What can the rejected applicants do if there are not happy with the final decision taken on their eligibility? Could you briefly describe the different steps of this process?

[Note for the interviewer: Make sure to cover the following: (1) When are the applicants informed about the right to complaint/appeal; (2) What is the procedure to file a complaint; (3) Who reviews the complaint/appeal; (4) Timeframe for reviewing the complaint/appeal by the social worker; (5) how and where the complaints are documented and stored; (6) is there a database of filed complaints]

Q21. Is there a complaint mechanism/procedure for beneficiaries? If yes, could you please describe each of its steps? What are the issues most frequently complained?

[Note for the interviewer: Also probe: (1) Are beneficiaries informed about the complaint procedure; (2) What is the procedure to file a complaint; (3) how and where the complaints are documented and stored; (4) is there a database of filed complaints; (5) what are the main issues reported]

Data management

Q22. How often are you obliged to share the lists of recipients with the PMT? Could you please show me how these lists look like?

Q23. What are the main challenges that you face with updating the lists of beneficiaries? Have you encountered problems when using the CPD?

[Note for the interviewer: Ensure the interviewee describes the functioning of the CPD as well as technical or other issues he may have encountered when using the application]

Disbursement

Q24. Could you please describe the process of payment to beneficiaries?

[Note for the interviewer: Make sure to cover the following aspects: (1) Where are the payments made?; (2) How often are the money paid out and for how many days during a period (e.g. if the payments are made in April, how many days during April are the money paid out)?; (3) How common are the cases that eligible beneficiaries do not/are not able to withdraw the money?]

Perception of impacts and way forward

Q25. What do you think are the short-term and long-term impacts of the project?
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

[Note for the interviewer: the perceived impacts can be positive or negative; probe if there are specific impacts to the beneficiaries, their families and their communities]

Q25.a. Do you think the impacts (or some of the impacts) are likely continue after the project ends? Why?

Q26. Do you see any effects of the project to the men in the families (esp. the husbands)? If yes, what effects?

Q26.a. Do you see any changes in the relationships between the women and their husbands due to the project? If yes, could you please describe them?

[Note for the interviewer: the effects can be positive or negative]

Q26.b. Have you encountered family conflicts or domestic violence related to the money received by the beneficiaries? Were the conflicts resolved? If yes, how? Did you play a role in trying to resolve the conflict?

Q27. Have you encountered complaints or concerns from non-beneficiary families (families without children 0-24 month in the targeted areas) about the fairness of the project?

Q28. Have you encountered complaints or concerns from families/communities outside of the targeted areas regarding the fairness of the project?

Q29. What do you think the end of the project is going to change in the lives of its beneficiaries?

Q30. What do you think are the expectations of the beneficiaries after the project ends?

Q31. What do you think could be improved in the project? If this project is to be replicated in the future, what would you recommend to change/improve?

Closing the interview Interviewer thanks the participant(s) for her/his time and their contributions to the discussion.
Annex 10. Interview guide: Health workers

Semi-structured interview guide for interviews with Regional Health Directorate/Health Promotion Officer/Nutrition Field Officer/Community Health Nurse/Officer in Charge

Date:

Location:

Interlocutor:

**Introduction and consent**

_Interviewer:_ Good morning/afternoon, Sir/Madam _________. Thank you very much for giving us the opportunity to interview you. My name is ___________ and I work for Social Policy Research Institute.

As you might have been informed when this interview was scheduled, we are independent evaluators that are currently looking at the BReST Cash Transfer Project to better understand what worked and what did not during its implementation. This would include success, progress, challenges and barriers in the implementation of the project.

To gain an understanding on the issue, we are interviewing different institutional representatives at the national, regional and local level along with local implementing partners including the NGOS, local leaders in the community, household members and, direct beneficiaries of the BReST project, (that is, mothers with children under two).

Today I would like to discuss with you about different aspects related to the implementation of the BReST project including informing and outreach activities, identification and verification of beneficiaries, disbursement of payments, as well as the key challenges that you face with implementation.

This interview will last 1-1.5 hours and we will take notes and record our exchanges so that we do not miss any information. The information that you provide will be treated with confidentiality, it will not be shared with other parties, and will only serve for the purpose of this evaluation.

If there are any statements that you do not want recorded, please let us know and we will turn the recorder off.

Do you have any question you want me to answer before we start?
General Questions

Q1. I would like to start the interview with a brief introduction. Could you please tell me for how long you have been in your current position, and how long you have been involved in the BReST project?

Q1.a. What have been your roles in the various phases of the project?

Q2. Have you been involved in the design or planning phase of the BReST project? If yes, had you at that time identified any relevant challenges for the implementation of the project? Was the PMT made aware of your concerns? Were these challenges addressed before and during the implementation of the project?

[Note for the interviewer: If the respondent has only been involved in the project recently, probe whether their predecessors were involved in the design and planning phase, and if they know these processes before they join]

Q3. Who are the beneficiaries you serve in the BReST project?

Q4. Could you please describe the type of activities that you carry out to reach the expected project beneficiaries? How do you interact with them?

[Note for the interviewer: Probe on the different activities constituting the mandate of Social Workers, i.e. operational aspects other than mobilisation, sensitization and education: (1) identification and registration of beneficiaries; (2) supervision of cash payments; (3) oversight of investigation processes on project misconduct; (4) complaints filing; (5) others.]

Q5. Did you also participate in the implementation of the Maternal and Child Nutrition and Health Results Project? What kind of dialogue or coordination process exists between these two projects at your level?

[Note for the interviewer: If they respond NO, briefly describe the project (describing it as a World Bank project could help) to ensure the interviewee(s) exactly knows what is being referred to]

Capacity development

Q6. In the course of program implementation, did you receive training(s) to help you achieve program objectives? If yes, what type of training did you receive? Are there other trainings you wish you had received? If yes, which ones?

Mobilization and sensitization activities

Q7. Did you carry out the information and outreach activities of the BReST project? If yes:

Q7.a. could you please describe the information and outreach activities you carried out? At which stages of the project did you conduct these activities, what type of information do you typically provide, through what channels/means?

[Note for the interviewer: prompt the use of different channels e.g. face-to-face, community radio, certain events in the community]

Q7.b. Who are the targets of the information campaigns and the outreach activities?
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

[Note for the interviewer: clarify if the activities are only targeted to beneficiaries, or also other community members; is there specific activities targeted to?]

Q7.c. Which activities do you think have proven more successful in reaching the potential beneficiaries? Do you think that these activities increase mother’s knowledge on IYCF practices, and have an impact on demand and health service utilization?

Q7.d. What else may need to be done to improve community/parents’ awareness and how?

Q8. Are other institutions/stakeholders involved in mobilization and sensitization activities of the BReST project? If yes, could you briefly describe the activities and the institutions involved?

Eligibility and enrolment in the BReST project

Q9. What were the main challenges that you faced in reaching potential beneficiaries to inform them about the BReST project, its eligibility criteria/requirements, and how they can realize their rights?

Q9.a. What are the differences in challenges between reaching out to women that gave birth in the health facilities and those who didn’t?

Q10. In the community you cover, are there still mothers with children under 2 who are not registered to the project? Why do you think these mothers are not registered?

[Note to interviewer: Ask to list all the key reasons for not registering in the project (in case they find it difficult to articulate, then share the following to take the discussion forward)?]

• Long distance to get to health facilities
• No transport is available
• Transport costs are high (unaffordable)
• Mothers are busy
• Mothers/Parents do not have knowledge about advantages of young children good nutrition practices
• Mothers/Parents are not aware of the project
• Others (Please specify): ______________

Complaint/appeals in the BReST project

Q11. What kind of complaints/appeals (if any) are generally filed by beneficiaries? What is done to address these complaints? How are the complaints documented?

Health and nutrition of women and children

Q12. What are the most prevalent diseases among women of reproductive age in this region? In your opinion, what are the main causes of these diseases?

Q13. What are the most prevalent diseases among young children in this region? In your opinion, what are the main causes of these diseases?
Q13.a. What about the main causes of underweight, wasting, and stunting?

Q13.b. How are these issues related to socio-economic status of the affected families? In your opinion, are certain groups of population more prone to diseases and malnutrition compared to others? Which ones?

Q14. According to your experience in this health district, what factors impact access to and utilization of healthcare services among those that are ill or injured, in particular children under 2 and women (lactating/pregnant)?

Q15. Do you think in the past few years more mothers have used health services (antenatal consultations, delivery, nutrition services, etc.)? If yes/no, what are the reasons for this increase/no increase. Please rank 5 top reasons (for increase or no increase) of health services utilisation.

Q16. In your view, if and how do the following conditions of parents/family affect the way they feed their children and babies:

1. Poor parents
2. Illiterate parents
3. Parents from ethnic minorities
4. Religion of parents
5. Single mothers
6. Rural parents
7. Co-habiting parents
8. Others (please specify)

Q17. How are the nutrition programs – including provision of food assistance – organized and delivered in the country, and in particular in this region/health facility?

Q18. What issues do you face in delivering services for the prevention and treatment of malnutrition?
Q18.a. What are some of the main issues that you face with take-up of such services?

[Note for the interviewer: Ask about whether the caretakers have the time and the financial means to follow the schedule for receiving such services.]

Q19. What are the main bottlenecks, if any, that you face with covering the entire population in your region/health facility with healthcare and nutrition services in terms of resources (human and financial), infrastructure and equipment and materials?

• Number of staff in proportion with the catchment population
• Infrastructure of facilities: size and quality of facilities such as access to water, sanitation, doors and windows, number of rooms, quality of construction materials of the health facility (for hospitals, also number of beds)
• Supply of medicine, equipment and other material
• Financing.

Q19.a. Does the BReST project help address some of these bottlenecks? If yes, how?

Q20. What are the key challenges that hinder your work, please explain? Please rank the top 5 key challenges that affect your work? Please share your thoughts on what should/could be done to address these and how it may facilitate your work?

Q21. In your opinion, what are the challenges faces in this community that affects their wellbeing?

[Note for the interviewer: Facilitate the discussion by asking about food security, climate conditions, availability of jobs, access to and availability of basic services, water and sanitation infrastructure, housing conditions.]

Perceived impacts of BReST project and way forward

Q22. In your view, what, if anything, has the BReST project changed in the lives of (registered) children and parents? Probe further by asking if it reduces the risk/cases of disease, malnutrition, negative impacts of shocks, death and if yes how.

Q22.a. In your opinion, what could have been done (differently) in order to increase the coverage and the impact of the project?

Q23. In your view, are there any unintended (positive or negative) effects of the BReST project for communities? How have those affected the health services delivery and services utilisation? Please share evidences and examples, and how those could be addressed.

[Note for the interviewer: unexpected impacts arising from specific aspects of the project e.g. media campaigns, supplies, training, cash transfers]

Other issues

Q24. Is there anything we did not discuss during the interview that you think we should take into account in the evaluation?
Interviewer thanks the interviewees.
Annex 11. FGD guide: VDCs and VSGs

Semi-structured interview guide for FGDs with partner Village Development Committees (VDCs) and Village Support Group (VSGs)

Date:

Location:

Interlocutor:

Introduction and consent

Interviewer: Good morning/afternoon, Sir/Madam __________. Thank you very much for giving us the opportunity to interview you. My name is ___________ and I work for Social Policy Research Institute.

As you might have been informed when this interview was scheduled, we are independent evaluators that are currently looking at the BReST Cash Transfer Project to better understand what worked and what did not during its implementation. This would include success, progress, challenges and barriers in the implementation of the project.

To gain an understanding on the issue we are interviewing different institutional representatives at the national, regional and local level along with local implementing partners including the VCDs/VSG, local leaders in the community, household members and, direct beneficiaries of the BReST project, (that is, mothers with children under two).

Today I would like to discuss with you about different aspects related to the implementation of the BReST project including informing and outreach activities, identification and verification of beneficiaries, disbursement of payments, as well as the key challenges that you face with implementation.

This interview will last about one hour and we will take notes and record our exchanges so that we do not miss any information. The information that you provide will be treated with confidentiality, it will not be shared with other parties, and will only serve for the purpose of this evaluation.

If there are any statements that you do not want recorded, please let us know and we will turn the recorder off.

Do you have any question you want me to answer before we start?

Q1. I would like to start the interview with a brief introduction. Could you please describe your position and role within the VDC and VSGs? For how long have you been members of the VDC and VSGs? How would you describe the role of your the VDC or VSGs in the community?

Q2. What was the nature of your collaboration with the BReST project? I am interested to learn from you how your organization was involved in the 5 steps of the BReST Social Transfer delivery process:
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

(1) information and outreach; (2) identification; (3) verification; (4) compilation of lists of beneficiaries; and (5) disbursement of payments.

[Note for the interviewer: Make sure you cover all the stages and refer to each one of them separately if the interviewee skips anything]

Q3. How do you feel about the method of cash delivery used in the BReST project? Do you think there are better or more efficient ways to deliver the money to beneficiaries?

Q3.a. Do beneficiaries have access to the banking system? How far is the closest banking service from your community?

Q3.b. What about mobile money transfer? Do beneficiaries have access to mobile phones? Are they able to read and operate text messages?

Q4. In your opinion, what are the main challenges this community is facing in terms of wellbeing of the people?

[Note for the interviewer: Facilitate the discussion by asking about food security, climate conditions, availability of jobs, access to and availability of basic services, water and sanitation infrastructure, housing conditions.]

Q5. In your opinion, does the BReST project interventions take into account the local specificities in terms of culture and social norms? Please elaborate which cultural and social norms are taken into account and how, as well as those that which were not taken into account.

Q6. Are there any other projects or mechanisms (including traditional mechanisms) in the community intended to take care of children under 2 and/or their mothers? If yes, could you elaborate a little on such projects/mechanisms?

Q5.a. How is the collaboration between these projects/mechanisms and the BReST project?

Q7. Did you also participate in the implementation of the Maternal and Child Nutrition and Health Results Project (MCNHRP)? If yes, what were your roles that project?

[Note for the interviewer: If they respond NO, briefly describe the project to ensure the interviewee(s) exactly knows what is being referred to (describing it as a World Bank project could help)]

Q7.a. In your opinion, what are the complementarities, similarities and differences between the MCNHRP and the BReST project?

Q7.b. What are the differences between the MCNHRP and the BReST project in the way they engage the VDCs and VSGs? What about remuneration?

Capacity development

Q8. In the course of program implementation, did you receive training to help you achieve program objectives? If yes, what type of training did you receive?

Mobilization and sensitization activities
Q9. Did you carry out the information and outreach activities of the BReST project? If yes:

Q9.a. could you please describe the information and outreach activities you carried out? At which stages of the project did you conduct these activities, what type of information do you typically provide, through what channels/means?

[Note for the interviewer: probe whether they use different channels e.g. face-to-face, community radio, certain events in the community etc]

Q9.b. Who are the targets of the information campaigns and the outreach activities?

[Note for the interviewer: clarify if the activities are only targeted to beneficiaries, or also community members or other groups; is there specific activities targeted to men in the families/communities?]

Q9.c. In your opinion, what is the impact of these activities on mother’s knowledge on IYCF practices, and on demand and health service utilization?

Q9.d. Which activities do you think have proven more successful in reaching the potential beneficiaries? Why? What else may need to be done to improve community/parents’ awareness and how?

BReST coverage and challenges
Q10. In the community, are there still mothers/children under 2 who are not registered to the project? Could you elaborate on reasons why you think these mothers/children did not register?

[Note to interviewer: Ask to list all the key reasons for not registering children (in case they find it difficult to articulate, then share the following to take the discussion forward)?]

1. Long distance to cover to get to health facilities
2. No transport is available
3. Transport costs are high (unaffordable)
4. Mothers are busy
5. Mothers/Parents do not have knowledge about advantages of young children good nutrition practices
6. Mothers/Parents are not aware of the project
7. Others (Please specify): ______________

Q11. What were the main challenges you encountered during the project implementation?

[Note to the interviewer: Ask about the challenges for each step of the implementation in which the VDC/VSG was involved]

Perceived impacts and way forward
Q12. In your opinion, what have been the main successes of the BReST project in your community? Could you please share a human success story made possible thanks to the BReST project?
Q13. In your view, how did the BReST project impact the lives of (registered) children and parents. If positive impact is mentioned: Do you think these impacts are sustainable?

[Note to the interviewer: Probe further if necessary by asking if it changes the risk/cases of disease, malnutrition, negative impacts of shocks, death and if yes how].

Q14. In your opinion, what could have been done (differently) in order to increase the coverage and the impact of the project?

Q15. In your view, are there any unintended (positive or negative) impacts of the BReST project for communities, children and mothers, and others?

   Q15.a. How have those affected the well-being of beneficiaries and the community in general? Please share evidences and examples.

   Q15.b. If the unintended impacts are negative, how could they be addressed?

Q16. Is there anything we did not discuss during the interview that you think we should take into account in the evaluation?

   Interviewer thanks the interviewees.
Annex 12. FGD guide for beneficiaries

Focus Group Discussions (FGDs) guide for interview with mothers of children aged less than 2 years benefiting from the BReST Cash Transfer or their procurators

Date: 

Location: 

Moderator(s): 

Duration of FGD: hours minutes 

Notes: 

Introduction and consent

Good morning/afternoon everyone. Thank you very much for making time to join the discussion today, we appreciate it.

My name is _____________, and together with my colleague ______________ we work for Social Policy Research Institute.

As you may know, we are independent evaluators that are currently looking at the BReST Project to better understand what worked and what did not during its implementation. This would include success, progress, challenges and barriers in the implementation of the project.

The BReST project refers to the monthly sum of GMD 600 provided to mothers of children aged less than two years since April 2017. The cash transfer aims at reducing young child malnutrition by improving nutrition status and care practices for women with young children.

Today we would like to discuss with you about different aspects of the BReST project. We are particularly interested to learn about what you know of the BReST project and the process of registration to the project, the events happening on a typical payment day as well as practices regarding child feeding, health and expenses in your household.

This discussion will last around 2 hours and we will take notes and record our exchanges so that we do not miss any information. We assure you that this information will not be shared with anyone else, that your name will not be mentioned and that it will be used only for the purposes of this evaluation. If there are any statements that you do not want recorded, please let us know and we will turn the recorder off.

Are you all still willing to participate and have us take notes and record?

[Note for moderator: Do ask for oral consent]

We would also appreciate if only one person talks at a time, so that we can hear everybody’s opinions and experiences, and so that everyone gets a chance to participate in the discussion.

Introduction
Let’s start with a brief introduction. Could each of you please tell us your age, where you live (village/town), whether you are the beneficiary of the BReST project or a procurator, the number of children you (or the person you represent) have, and the ages of the children.

[Note for the notetaker: The number of the participant in the Roster is the number that she/he should be assigned in the Transcript. Record in the FGD Roster: gender, age and village/town of residence of respondent, whether the respondent is the beneficiary or procurator, the number of children the beneficiary has and the ages of the children. If the respondent is a procurator enquire about his/her relation to the beneficiary.]

Q1. Did you (or the person you represent) receive other social cash transfers before or at the same time as the BReST project? If yes, what project(s)?

[Note for moderator: If they respond NO or are unclear, inquire about the World Bank’s Maternal and Child Nutrition and Health Results Project (or use the local name, if any), briefly describe the project to ensure respondents recall the project]

Questions about registration to the project

Q2. How did you find out about BReST project? Who informed you about it, and through which channels?

[Note for moderator: probe if the channels include community radio or commercial radio station]

Q3. What type of information did you receive about BReST before you join the project?

[Note for moderator: Probe with the following, (a) Were you informed about the eligibility criteria; (b) About the documents necessary to register; (c) Where new mothers can register; (d) The amount of the benefit; (e) How often the benefit is provided and where it can be obtained; (f) What are the obligations of the beneficiaries; (g) What are the support services provided as part of the project; (h) Whether the rejected applicants have the right to complain/appeal and what is the procedure to file it]

Q4. Did you (or the person you represent) give birth in a health facility linked to the BReST project? Did you receive care during your pregnancy in this health facility? How distant is the health facility from your residence?

Q5. Can you describe the process when you registered for the BReST project?

[Note for moderator and notetaker: Also ask the following, (a) When did you register (note in the Roster whether it was automatic after delivery at a Health Facility or through the voluntary registration process); (b) How did you register; (c) What documents did you submit for registration; (d) How long did the whole process take before you obtained the first payment]

Q6. Did you encounter any difficulty during registration and proving eligibility to the project?

Q6.a. If you were also a beneficiary of the World Bank cash transfer project, do you think the registration to BReST was more difficult, less difficult, or similar to the World Bank project? Please explain.

[Note for the moderator: If they mention other projects, also ask for comparison with other programs]
Q7. In your community, who are the caregivers who are more likely to register for the BReST project? Why? Who are the caregivers who are less likely to register for the BReST project? Why?

Questions about the method of payment

Q8. How do you feel about the method of cash delivery used in the BReST project? Do you think there are better or more efficient ways to deliver the money to beneficiaries?

Q8.a. Do you have access to the banking system? How far is the closest banking service from your community?

Q8.b. What about mobile money transfer? Do you have access to mobile phones? Are you able to operate text messages?

Questions about payment day

Q9. Can you please describe a typical payment day from the moment you wake up to the moment you go to sleep?

Q9.a. If you have been absent in the payment day, what were the reasons?

[Note for moderator: Also ask the following, (a) How do you arrange for your daily work and tasks in your absence; (b) How do you reach the HF/ payment point; (c) What are the steps at the payment point before receiving the benefit; (d) Did you like the mother and infant welfare sessions and did you learn new things there?]

Q10. Are there many mothers of children under two years in your community who receive the BReST project? Would you say that only a few, many, or almost everyone with children under two years in your community receives the BReST project?

Q11. What do you think are the reasons some of the mothers/ carers of children under two years in your community do not receive the BReST project?

[Note for the moderator and note-taker: Ask each participant to list 2 or 3 main reasons why some mothers do not receive the BReST project. Record the reasons in a blank sheet of paper and rank them in order of importance, from most important to least important, depending on how many times they were mentioned. The moderator lists the 3-5 main reasons and tries to understand from the group whether they agree with this selection]

Q12. In what ways do you think that registering for the BReST project and receiving payments could be made easier for the members of your community? What changes do you think would make obtaining the benefit easier?

Questions regarding child feeding and health practices

We would now like to ask you a few questions about some aspects of your daily life outside the payment days.

Q13. When your baby is hungry, what do you usually feed her/ him with? How old is she/ he? Do you feed the baby differently over time? What about a typical feeding for a newborn and for a growing child?

[Note for the moderator: Ask about (a) initial feedings whether they were exclusively composed of breast milk. If breast milk was supplemented, ask with what? (b) when was breastfeeding stopped and
the reason why; (c) when the child starts a semi-solid diet, what was it usually composed of; (d) do you buy or produce these food stuffs?)

Q14. How do you know of these practices? From your own experience, from other mothers in the family or community, from radio or other channels, from mother and infant welfare sessions?

Q15. Were the mother and infant welfare sessions useful to you for learning about child nutrition? How were they useful and how could they be improved?

Q16. Did you / will you share some of the IYCF lessons with other mothers in your family or community?

Q17. If your child is not doing well (vomiting, diarrhea, fever, coughing, etc.), what do you do to help her/ him? Who do you ask for help? To neighbors, local authorities, pharmacies, health centers, traditional healers?

Q18. For those who have more than one child, did you take the older child/children to the HF when they were 0-2 years old? If yes, how often? If not, why?

Q18.a. How do you now feel about going to the HF in case your child is not feeling well? Or if you are now pregnant again?

Q18.b. How do you now feel about going to the HF if you are now pregnant again? Do you know of services they offer before you have the baby, when you are delivering the baby and after? Tell us more.

[Note for the moderator: If they were not going to HF before receiving the BReST project, probe for the possible reasons (no money, difficult to access, not confident in doing so, not allowed to do so, staff’s attitude, quality of services, what people say about HFs, etc.)

Questions regarding the management of money in the household

Now we would like to know more about the shopping habits and arrangements in your household.

Q19. Before receiving the BReST project, your household managed its expenses in a certain way, did that change with the receipt of the BReST payments? If yes, how?

Q19.a. How did you spend the money you received from the BReST project? Are there specific things/services you purchased using the money from BReST? What are the main items?

Q19.b. Do you now still obtain those items? Will you continue to obtain those items in the future? If yes, where will the money come from?

[Note for the moderator: if they continue to purchase the items, probe whether they re-allocate the family budget from other expenses]

Q19.c. Did you manage to save/ invest some of the money received from the BReST project?

[Note for the moderator: Probe for applicable saving mechanisms: investment in livestock, working tools and participation in savings groups, etc.]

Q20. In your opinion, who within the household should be receiving the BReST transfer and why?

Q21. In families, spending decisions can either be taken by the household head, the main income earner or jointly, how is spending decided for in your family? What about doing the shopping?
Q21.a. And what about the money from the BReST project? Are there any differences?

Q21.b. Did receiving money from BReST change your decision power over money issues? If yes, how?

Q21.c. If yes, what do you think will happen in respect to your decision power when you stop receiving money from BReST project?

[Note for the moderator: if the participants are at ease with this theme, ask whether the arrangement caused any problems?]

Questions regarding documentation of the children

Q22. Does your child, who was registered in the BReST project, have a birth certificate? Could you explain why or why not the child has a birth certificate?

Q22.a. For those of you who have other children, do your other children have birth certificate? If not, why? Could you explain why or why not the children have birth certificates?

Q22.b. What do you think are the benefits of having a birth certificate?

Q22.c. What are the main challenges you encountered to obtain a birth certificate?

[Note for the moderator: explore what factors affect the children having birth certificates or not, and whether the beneficiaries understand the benefits of obtaining birth certificates]

Closing the session

Moderator thanks the participants for their time and their contributions to the discussion.

Note-taker fills out the Roster of FGD participants with the rest of information.
## Focus group discussions (FGDs) – Roster

<table>
<thead>
<tr>
<th>Participants</th>
<th>1</th>
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<td>Ages of the children (from youngest to oldest) * If more children, continue writing under this table</td>
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</table>

\(^{18}\) Codes for relationship to beneficiary. 1=partner; 2=child; 3=mother/father; 4=parent in-law; 5=sister/brother; 6=aunt/uncle; 7=distant relative. If other than these, type 8 in the box and write it down in text.
Annex 13. FGD guide: Spouses of beneficiaries

Focus Group Discussions (FGDs) guide for interview with spouses/partners of the beneficiaries of the BReST project

Date:

Location:

Moderator(s):

Duration of FGD: ______ hours ______ minutes

Notes:

**Introduction and consent**

*Good morning/afternoon everyone. Thank you very much for making time to join the discussion today, we appreciate it.*

*My name is _____________, and together with my colleague _____________ we work for Social Policy Research Institute.*

*As you may know, we are independent evaluators that are currently looking at the BReST Project to better understand what worked and what did not during its implementation. This would include success, progress, challenges and barriers in the implementation of the project.*

*The BReST project refers to the monthly sum of GMD 600 provided to mothers of children aged less than 24 months since April 2017. The cash transfer aims at reducing young child malnutrition by improving nutrition status and care practices for women with young children.*

*Today we would like to discuss with you about different aspects of the BReST project. We are particularly interested to learn about what you know of the BReST project and the process of registration to the project, the events happening on a typical payment day as well as practices regarding child feeding, health and expenses in your household. We would also like to know what has changed in your household, and with your partner since she started benefiting from the transfer.*

*This discussion will last around 2 hours and we will take notes and record our exchanges so that we do not miss any information. We assure you that this information will not be shared with anyone else, that your name will not be mentioned and that it will be used only for the purposes of this research. If there are any statements that you do not want recorded, please let us know and we will turn the recorder off.*

*Are you all still willing to participate and have us take notes and record?*

*[Note for moderator: Do ask for oral consent]*

*We would also appreciate if only one person talks at a time, so that we can hear everybody’s opinions and experiences, and so that everyone gets a chance to participate in the discussion.*
Introduction

Let’s start with a brief introduction. Could each one of you please introduce yourself by telling us your age, where you live (village/ town), the number of children you have and the ages of the children.

[Note for the notetaker: Record in the FGD Roster: age and village/ town of residence of respondent, the number of children the beneficiary has and the ages of the children. Assess the distance to the health facility.]

Q1. When and for how long did your spouse become a beneficiary of the BReST project?

[Note for moderator: If they respond NO or are unclear, inquire about the World Bank’s Maternal and Child Nutrition and Health Results Project (or use the local name, if any), briefly describe the project to ensure respondents recall the project]

Q2. What do you know about the BReST project? What does it provide to the beneficiaries? What are the project activities that the beneficiaries participate in? What do you think is the objective/purpose of the project?

[Note for moderator: Probe the respondents’ knowledge about the different components: (1) the cash benefits; (2) nutrition education/information; (3) vitamin A and deworming services; (4) assessments of the child’s health]

Q3. Did your wife or your family also receive other social cash transfers before or at the same time as the breast project? If yes, what project(s)?

[Note for moderator: If they respond NO or are unclear, inquire about the World Bank’s Maternal and Child Nutrition and Health Results Project (or use the local name, if any), briefly describe the project to ensure respondents recall the project]

Questions about registration to the project

Q4. How did you or your spouse heard of the BReST project? Who informed you or your family about it, and through which channels?

[Note for moderator: probe if the channels include community radio or commercial radio station]

Q4.a. What type of information did you receive about BReST before you join the project?

[Note for moderator: Probe with the following, (a) Were you informed about the eligibility criteria; (b) About the documents necessary to register; (c) Where new mothers can register; (d) The amount of the benefit; (e) How often the benefit is provided and where it can be obtained; (f) What are the obligations of the beneficiaries; (g) What are the support services provided as part of the project; (h) Whether the rejected applicants have the right to complain/appeal and what is the procedure to file it]

Q5. Did your wife give birth in a health facility linked to the BReST project? If not, why?

Q6. Did your wife encounter any difficulty during registration and proving eligibility to the project?

Q6.a. Did you accompany her during the registration process? If not, did she go alone or accompanied by another person?

[Note for moderator and notetaker: Try to see whether the beneficiary has completed the registration process alone or she needed support from her spouse or other people]
Q6.b. If your wife was also a beneficiary of the World Bank cash transfer project, do you think the registration to BReST was more difficult, less difficult, or similar to the World Bank project? Please explain.

[Note for the moderator: If they mention other projects, also ask for comparison]

Q7. In your community, who usually registers for the BReST project? Is it the mother or her family members? Those who live closer to the Health Facilities (HF)? The mothers who are well-off? What about carers of orphans or foster children?

[Note for the moderator: Use synonyms of “well-off” if necessary (comfortable, prosperous, etc.)]

Q8. In what ways do you think that registering for the BReST project and receiving payments could be made easier for the members of your community? What changes do you think would make obtaining the benefit easier?

Questions about payment day

Q9. Can you please describe a typical payment day from the moment your wife wakes up to the moment she goes to sleep?

[Note for moderator: Also ask the following, (a) How do you and your wife arrange the daily work and tasks in her absence; (b) How does she reach the HF/ payment point; (c) Do you accompany her?; (d) Other than receiving the money, you know what other activities she does in the payment point?]

Q10. Are you comfortable with the fact that she receives this money? Why?

Q11. Do you think that transfers should be paid to the head of household rather than to mothers?

Q12. Have you ever joined your wife on a payment day or received the cash transfer as her procurator?

Questions regarding the management of money in the household

Now, we would like to know more about the shopping habits and arrangements in your household.

Q13. Before receiving the BReST project, your household managed its expenses in a certain way, did that change with the receipt of the payments? If yes, how?

Q13.a. Are there particular items that were bought using money from the BReST project? If yes, what are they?

Q13.b. Does your family now still obtain those items? Will you continue to obtain those items in the future? If yes, where will the money come from?

[Note for the moderator: if they continue to purchase the items, probe whether they re-allocate the family budget from other expenses]

Q13.c. Did your wife manage to save/ invest some of the money received from the BReST project?

[Note for the moderator: Probe for applicable saving mechanisms: investment in livestock, working tools and participation in savings groups, etc.]

Q14. In families, spending decisions can either be taken by the household head, the main income earner or jointly, how is spending decided for in your family?

Q14.a. And what about the money from the BReST project? Are there any differences?
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

Q15. Did you notice any changes in the way your wife spends money since she received the BReST project? Tell us more.

[Note for the moderator: if the participants are at ease with this theme, ask whether the arrangement caused any problems?]

Questions about health practices

Q16. If your child is not doing well (vomiting, diarrhea, fever, coughing, etc.), what do you do to help her/him? Who do you ask for help? To neighbors, local authorities, pharmacies, health centers, traditional healers?

Q17. For those who have more than one child, did you take the older child/children to the HF when they were 0-2 years old? If yes, how often? If not, why?

Q17.a. How do you now feel about going to the HF in case your child is not feeling well? Or if your wife is pregnant again?

Q17.b. Do you know of services they offer before you have the baby, when you are delivering the baby and after? Tell us more.

[Note for the moderator: If they were not going to HF before BReST project, probe for the possible reasons (no money, difficult to access, not confident in doing so, not allowed to do so, staff’s attitude, quality of services, what people say about HFs, etc.)]

Questions regarding documentation of the children

Q18. Does your child, who was registered in the BReST project, have a birth certificate? Could you explain why or why not the child has a birth certificate?

Q18.a. For those of you who have other children, do your other children have birth certificate? If not, why? Could you explain why or why not the children have birth certificates?

Q18.b. What do you think are the benefits of having a birth certificate?

Q18.c. What are the main challenges you encountered to obtain a birth certificate?

[Note for the moderator: explore what factors affect the children having birth certificates or not, and whether the beneficiaries understand the benefits of obtaining birth certificates]

Closing the session

Moderator thanks the participants for their time and their contributions to the discussion.

Note-taker fills out the Roster of FGD participants with the rest of information.
### Focus group discussions (FGDs) – Roster

<table>
<thead>
<tr>
<th>Participants</th>
<th>1</th>
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Annex 14. List of key informants

For the sake of anonymity, only position and institutions of meetings are presented. The dates of meeting can be found in Annex 17 and 18.

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<td>National Nutrition Agency (NaNA), Data Analyst</td>
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<td>Ministry of Health, Deputy Permanent Secretary</td>
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Annex 15. Quantitative methods (inception stage)

The aim of the quantitative analysis is to provide evidence of the project impacts on beneficiaries. More specifically, the analysis should provide evidence of a reduction in the prevalence of acute malnutrition in children under two enrolled in the project, and an improvement in the care and feeding practices. Other effects on beneficiaries may be observed that are different from those predicted in the theory of change. This assessment qualifies the latter as side effects.

In addition to administrative data from the project monitoring and evaluation system, primary data will be collected through household survey in order to see if the project had indeed the intended effects and impact on its beneficiaries.

1. Primary data collection

This evaluation will follow a post-project design with a non-randomized comparison group. The data that will be collected will serve mainly to compare BReST beneficiaries to non-beneficiaries at the end of the project, in areas covered by MCNHRP. This means that both comparison and treatment groups will be MCNHRP recipients. Basically, the evaluation will determine the value added (if any) of the BReST project over the MCNHRP. Doing the comparison with non MCNHRP recipients would be misleading as it would have been difficult to dissociate the impact of BReST from the impact of the MCNHRP.

1.1. Probabilistic sampling strategy

The data collection will include both comparison and beneficiary health facility’s catchment areas (HF). Given the universal targeting of BReST, a HF will be either a beneficiary or a comparison HF. The comparison HFs were selected with the support of local implementers such as the regional NaNA officers and the regional social welfare officers, in order to make sure that there is no BReST beneficiary in the comparison HF, and to avoid the risk of contamination of the comparison group as some recipients were located in non-beneficiary HFs. The distance between comparison and treatment HFs is another precaution taken in order to avoid any contamination of comparison HFs by BReST’s beneficiaries. In fact, depending on the region, we ensured that comparison HFs were located at least 20 km and not more than 100 km from treatment HFs. In the questionnaire, a question was added in order to know if the woman/household received any other cash transfer (other than BReST and MCNHRP) and to comparison for this, so as to avoid any contamination from these other projects.

The purpose of the evaluation is to test whether the acute malnutrition decreased, to this end a one-tailed test is appropriate. To estimate the actual sample size, STATA command power was used. Since the results will be tabulated at the region level, a minimum sample size was determined for each of the 3 regions in the BReST project. The following information
was used for the computation for the 3 regions: a margin of error of 5%; a desired level of power of 80%; a balanced sample size between comparison and treatment groups, and a common standard deviation of 1. The baseline prevalence (from SMART 2015) as well as the expected prevalence among the treatment group (counting for the 10% decrease in prevalence) differ from one region to the other. Error! Reference source not found. presents the GAM prevalence used for each of the regions, and the minimum sample sizes found. The total sample size in order to capture a decrease of 10% in the prevalence of GAM, given a power of 80%, is 288. We will increase the sample size by about 10% to count for non-responses and other methodological errors or biases. The total sample will be 326.

All ten HFs under the BReST project will be visited; The number of questionnaires administered in each BReST HF will be proportional to the expected number of deliveries in the HF, as reported in the project operational manual. Five comparison HFs were selected. The comparison group is composed of HFs which benefited from the MCNHRP but not from the BReST project, and in which there is no BReST beneficiary. The respondents in each HF will be randomly selected in order to increase our chances to get the project’s true effect. The individual respondents will be mothers of children less than 3 years old (see Error! Reference source not found. for the distribution of respondents in comparison vs beneficiary groups). The random selection of beneficiaries was done using the list of beneficiaries provided by NaNA. The selected beneficiaries will be visited and interviewed. They will be located with the support of community health nurses and regional social welfare officers. The selection of beneficiaries was done at the HF level, and not at the village level. The same will be done for the comparison group.

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<th>Regions</th>
<th>Baseline GAM</th>
<th>Expected GAM for treatment group</th>
<th>Minimum sample size</th>
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<td>Treatment</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Kerr Cherno</td>
<td>Control</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Farafenni</td>
<td>Control</td>
<td>42</td>
</tr>
</tbody>
</table>
1.2. The questionnaire to be used

The version of the BReST February 2019 mini-survey questionnaire was adjusted as to include profiling questions, questions on income generating activities and possession of productive assets, water, sanitation and hygiene (WASH), Vitamin A supplementation, deworming, and MUAC measurement. Profiling questions include for instance questions on education and ethnicity. These questions will allow us to include covariate variables that potentially have an impact on the outcome of the project. Controlling for them have the potential to increase the precision of our impact estimate. One expected impact of the project is an increase in women’s empowerment, through their comparison of money and their involvement in income generating activities (IGA). A comparison between BReST beneficiaries and the comparison group will provide evidences (if any) of an impact of the project on its beneficiaries’ involvement in IGA and access to productive assets. Questions on WASH are important by themselves, but they also have an impact on the child’s nutrition and health status. Improvements in WASH due to the project can have a positive impact on children’s health and nutrition status. Vitamin A and deworming are among the Government priorities and will be monitored here to see if BReST had any impact on the uptake of take of Vitamin A supplementation and the use of deworming services, and hence contributed to the realisation of national objectives.

The questionnaire was piloted in Brikama near Banjul, on November 1st, 2019, and some adjustments were made in order to adapt the questionnaire to the local context and specificities. In total, 16 enumerators and 3 supervisors were trained for the purpose of starting data collection the first week of December 2019.
1.3. Main indicators to be used to assess the effects and impact of BReST project

Several outcome variables will be used in order to assess the effects and the impact of the project.

- **Assessment of prevalence of acute malnutrition**: The main indicator here will be the MUAC measurement. The MUAC is the SAM and GAM measurement indicator used for the BReST project. The indicator will be used to estimate the prevalence of acute malnutrition among children more than 6 months old using WHO cut-off scores, and the individual nutrition status of a child. Severe acute malnutrition (SAM) is defined as a MUAC of less than 11.5 cm, and global acute malnutrition (GAM) as a MUAC of less than 12.5 cm. The evolution of the prevalence of malnutrition will be analyzed, using the SMART 2015 as a baseline. The project target is a decrease of 10% in the prevalence of acute malnutrition.

- **Assessment of under-two feeding practices**: The indicators will assess if the project had an effect on infant and young children feeding practices. They include prevalence of exclusive breastfeeding among children under 6 months, child’s minimum dietary diversity, child’s minimum meal frequency, and the minimum acceptable diet, for children between 6 and 23 months.

- **Assessment of income generating activities**: During interviews with regional level stakeholders and FGDs with communities, an effect of the project that was often mentioned is an increase in women’s involvement in income generating activities, and the purchase of productive assets such as garden and livestock. We will look for such evidence in the analysis.

- **Assessment of WASH practices**: Questions were introduced in the questionnaire in order to assess WASH practices. In particular, the source of drinking water, handwashing practices, adequate sanitations, and children’s stool disposal practices. All these elements have an impact on children’s environment and hence his/her health and nutrition status and could have been impacted by the BReST project.

- **Use of vitamin A supplement and deworming services**: Both have an impact on child’s development. The frequentation of health facilities related to the project should have a significative impact on the use of vitamin A supplement and deworming services. All BReST beneficiaries have children between 2- and 3-years old today.

---

19 Exclusive breastfeeding means that the child receives only breast milk, and no other liquids and solids with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines. The standards for meal frequency are: 2 times for breastfed infants 6–8 months; 3 times for breastfed children 9–23 months and 4 times for non-breastfed children 6–23 months. Dietary diversity refers to the child receiving 4 or more of the following food groups: 1. grains, roots and tubers; 2. legumes and nuts; 3. dairy products (milk, yogurt, cheese); 4. flesh foods (meat, fish, poultry and liver/organ meats); 5. Eggs; 6. vitamin A rich fruits and vegetables; 7. other fruits and vegetables. Minimum acceptable diet refers to the percentage of children age 6-23 who had at least the minimum dietary diversity and the minimum meal frequency during the previous day.
Vitamin A and deworming services are applicable to all of them. We expect to have the same cohorts in comparison areas.

- **Possession of birth certificate**: This is probably the most important unintended effect of the project. Official identification documents, including birth certificates, were necessary in order to receive the social cash transfer. With the support of the ministry of health, beneficiary women without any identification documents were provided assistance to obtain birth certificate. The project should therefore have a significant impact on the possession of birth certificate of the mother. Although not part of the original objectives, as the project was running, it also included birth certificate services for beneficiary babies. This is expected to increase birth certificate possession among beneficiary babies.

The analysis will be done by sex of the child and age group (0-5 months, 6-8 months and 9-24 months) to see if the project has a differentiated impact according to age and sex. This divide is important since the needs of children vary according to their age. This is indeed reflected in the indicators to be used: exclusive breastfeeding relevant only for children under 6 months, while diversification is applicable only to children between 6 and 23 months.

### 1.4. Methods to capture the effect of the project

There is a multiplicity of methods to measure the impact of a project. The method that is chosen depends on the availability of data. For this impact evaluation, end line data will be collected, for both a comparison and beneficiary group. However, because of the absence of a valid baseline, the analysis will focus mainly on the differences between the comparison and the beneficiary groups at the end of the project, for most of the indicators. We can use the SMART 2015 results as a baseline for the BReST project only to assess the evolution of acute malnutrition, as SMART is also using the MUAC to assess acute malnutrition. Even in this case, it is not possible to differentiate BReST from non-BReST beneficiaries, meaning that we will have to assume the same baseline information for both comparison and treatment groups. Another assumption behind the method we will be using is that, as both groups have the same starting situation, the program is the only factor influencing any changes in the measured outcome at the end of the project. This is not actually true, as the outcome may be influenced by a variety of other factors. By including some of these other factors (for instance education, ethnicity, geographical location, or household size) in the regressions, we can comparison for their impact and improve at the same time the precision of our impact estimate.

Triangulation is another strength of the analysis, as the results of the quantitative and qualitative analyses will complement each other. The combination of the qualitative and
quantitative analysis should provide us with strong and valid evidences on the impact of the project.

1.5. Limitation of the quantitative analysis and mitigation strategy

As already stated, this evaluation will follow a post-project design with a comparison group. The main limitation of this type of design is the absence of a baseline. The SMART 2015 results will be used as a starting point for acute malnutrition. In addition, whenever possible and available, we will use HF information on GAM and SAM as baseline in order to comparison for any potential baseline differences. To compensate for the absence of a valid baseline, in addition to the use of a comparison group, several covariates variables susceptible to influence the impact of the project will be added in the regressions in order to comparison for them and have an impact estimate as precise as possible.

Another limitation of the evaluation when it comes to the comparison with the SMART 2015 is the limited comparability between the two datasets because of seasonality. SMART 2015 data collection took place between September 1st and October 6th 2015, while the end line evaluation data will be collected end November early December. September is toward the end of the lean season in the country, and acute malnutrition rates may be higher than in other periods of the year. On one hand, we should be cautious in interpreting BReST impact when comparing with the SMART 2015, but in the other hand, theoretically, the BReST project should have eased the negative impacts of the lean season on beneficiaries’ nutrition status, as the extra-cash should have been used to smooth food consumption during time of stress. As its name indicates, BReST is also a resilience building project. The estimated impact of the project on malnutrition should therefore be higher during lean season. Unfortunately, our data will not allow us to see these intra-year variations of GAM and BReST impact on it.

2. Analysis of administrative data

Two sets of administrative data were provided by NaNA. The first one is data from the regular monitoring and evaluation system. The dataset provides information on MUAC measurement, Vitamin A supplementation and deworming for several months, between February 2018 (9 months after the project start) and September 2019. MUAC measurement were used to estimate the prevalence of GAM and SAM. Comparisons were made with the entire population using the results from the SMART 2015. Vitamin A supplementation and deworming were used also for comparison with the entire population. All BReST beneficiaries were up to date for Vitamin A and deworming.

The main limitation of the data is the high number of missing observations. Part of the missing observations can be explained by the fact that the child was either absent during payment day or it is the procurator who came to collect the money. In February 2018, missing observations could be also due to children being less than 6 months. From May 2019, another explanation for missing values could be the graduation from the project, as children are
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReSt) 2016-2019

entitled to the transfer for 24 months. Despite all these possible explanations, the number of unexplained missing values is very high. This testifies of strong deficiencies in the project M&E system. Error! Reference source not found. presents a summary of data on MUAC measurement, including number of missing values, number of non-missing observations and minimum and maximum MUAC values. As the missing values do not seem to follow any pattern it is not expected that they could introduce bias. In the data analysis, missing values will not be imputed, and only non-missing observations will be used.

Table 16. MUAC measurement per months: missing values, number of observations, and minimum and maximum values

<table>
<thead>
<tr>
<th>Variable</th>
<th># missing obs</th>
<th># non-missing obs</th>
<th>Unique values of MUAC</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>febr-18</td>
<td>5,863</td>
<td>469</td>
<td>60</td>
<td>9.5</td>
<td>17.6</td>
</tr>
<tr>
<td>march-18</td>
<td>5,627</td>
<td>705</td>
<td>62</td>
<td>9.1</td>
<td>61</td>
</tr>
<tr>
<td>apr-18</td>
<td>5,633</td>
<td>699</td>
<td>64</td>
<td>9</td>
<td>18.5</td>
</tr>
<tr>
<td>may-18</td>
<td>4,101</td>
<td>2,231</td>
<td>74</td>
<td>9.5</td>
<td>19</td>
</tr>
<tr>
<td>june-18</td>
<td>4,091</td>
<td>2,241</td>
<td>76</td>
<td>9.1</td>
<td>61</td>
</tr>
<tr>
<td>july-18</td>
<td>3,414</td>
<td>2,918</td>
<td>70</td>
<td>9.8</td>
<td>19</td>
</tr>
<tr>
<td>aug-18</td>
<td>3,853</td>
<td>2,479</td>
<td>67</td>
<td>9.5</td>
<td>18</td>
</tr>
<tr>
<td>sept-18</td>
<td>2,573</td>
<td>3,759</td>
<td>76</td>
<td>9.2</td>
<td>19</td>
</tr>
<tr>
<td>oct-18</td>
<td>3,695</td>
<td>2,637</td>
<td>67</td>
<td>10</td>
<td>19.8</td>
</tr>
<tr>
<td>nov-18</td>
<td>3,571</td>
<td>2,761</td>
<td>70</td>
<td>8.5</td>
<td>18</td>
</tr>
<tr>
<td>dec-18</td>
<td>3,750</td>
<td>2,582</td>
<td>66</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>janv-19</td>
<td>5,330</td>
<td>1,002</td>
<td>59</td>
<td>10.5</td>
<td>18.5</td>
</tr>
<tr>
<td>febr-19</td>
<td>6,059</td>
<td>273</td>
<td>49</td>
<td>11.4</td>
<td>17.8</td>
</tr>
<tr>
<td>march-19</td>
<td>4,316</td>
<td>2,016</td>
<td>65</td>
<td>10.5</td>
<td>17.5</td>
</tr>
<tr>
<td>apr-19</td>
<td>4,151</td>
<td>2,181</td>
<td>67</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>may-19</td>
<td>4,126</td>
<td>2,206</td>
<td>61</td>
<td>10.5</td>
<td>18.1</td>
</tr>
<tr>
<td>june-19</td>
<td>4,290</td>
<td>2,042</td>
<td>63</td>
<td>10.5</td>
<td>19</td>
</tr>
<tr>
<td>july-19</td>
<td>4,523</td>
<td>1,809</td>
<td>61</td>
<td>10.5</td>
<td>18.5</td>
</tr>
<tr>
<td>aug-19</td>
<td>5,028</td>
<td>1,304</td>
<td>62</td>
<td>10.5</td>
<td>17.6</td>
</tr>
<tr>
<td>sept-19</td>
<td>5,564</td>
<td>768</td>
<td>56</td>
<td>10.5</td>
<td>18.6</td>
</tr>
</tbody>
</table>

The second set of data is the BReSt mini survey collected in February 2019 by NaNA. The survey collected information on IYCFP, including breastfeeding habits, consumption of solid, semi-solid, and soft foods, and counselling received by mothers (number, frequency and content). Prevalence of exclusive breastfeeding, minimum dietary diversification and frequency and content of counselling were analyzed. Unfortunately, the data do not provide information on age, necessary to estimate the minimum meal frequency.

Whenever possible, the results from the administrative data are compared with the results from the SMART 2015, the MICS 2018, the micronutrient survey 2018 and the National Nutrition Surveillance in 2016 and 2019. Data collection for the SMART 2015 was done
between September 1st and October 6th 2015, for the MICS between January and April 2018, and for the micronutrient survey between March 13th and May 4th, 2018. The data collection for the two National Nutrition Survey referenced in this evaluation was collected in February-March 2016 and February-March 2019. The administrative division used in the 3 national surveys are different from the division used in BReST project. Error! Reference source not found. presents the BReST regions and the corresponding local government administrations (LGA) used in the national surveys.

<table>
<thead>
<tr>
<th>BReST Regions</th>
<th>HF covered by BReST</th>
<th>Corresponding LGA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>North Bank Region (NBR)</strong></td>
<td>Essau HF</td>
<td>Kerewan</td>
</tr>
<tr>
<td></td>
<td>Kuntair HF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Albreda HF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ngayen Sanjal HF</td>
<td></td>
</tr>
<tr>
<td><strong>Central River Region (CRR)</strong></td>
<td>Brikamaba HF</td>
<td>Kuntaur LGA</td>
</tr>
<tr>
<td></td>
<td>Dankunku HF</td>
<td>Janjanbureh LGA</td>
</tr>
<tr>
<td></td>
<td>Kudang HF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kuntaur HF</td>
<td></td>
</tr>
<tr>
<td><strong>Upper River Region (URR)</strong></td>
<td>Basse HF</td>
<td>Basse LGA</td>
</tr>
<tr>
<td></td>
<td>Demba Kunda Koto HF</td>
<td></td>
</tr>
</tbody>
</table>

The following indicators were estimated: the share of children exclusively breastfed, child’s minimum dietary diversity, the content of counselling sessions received by BReST beneficiaries, the prevalence of global and severe acute malnutrition using the MUAC measurement, and the prevalence of vitamin A supplementation and deworming. The results are presented under preliminary results.
Annex 16. Survey questionnaire

Good morning/afternoon. My name is ........................UNICEF is conducting a survey to find out some basic health and nutrition information about how children are being cared for. We would very much appreciate your participation in this survey. The information you provide will help the Government to plan and improve existing nutrition and health services. The survey usually lasts about 30 minutes to complete and will be concluded with the measurement of your child’s Mid Upper Arm Circumference as was done in the health center. Whatever information you provide will be kept strictly confidential and will not be shown to other persons. Your participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this survey since your views are important.

Do you agree to participate in this survey?

1. Yes.       2. No

*If the answer is no, thanks the respondent and go to the next respondent.*

Do you have at least one child who is less than 3 years old?

1. Yes.       2. No

*If the answer is no, thanks the respondent and go to the next respondent.*

Section 1: Identification

a. Date of Interview (please select today's date):

b. Evaluation site:  
   See evaluation sites codes below.

|-------|-----------------|-----------|----------|---------------------|

c. Region  
   See region codes below.

|-------|---------------------------|---------------------------|------------------------|----------------------|

d. Name of Interviewer:

e. Name of supervisor:

f. Respondent ID Number

g. Name of Respondent

f. Were you a BReST beneficiary?

1. Yes.       2. No

*Make sure the respondent knows which project you are talking about. BReST project gave 600 dalasi each month to the mother in order to feed the child, and had health talks at the health facility.*
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

i. Did you receive any other cash transfer, other than the 600 dalasi from the BReST project and the 300 dalasi from the MCNHRP?  
   1. Yes    2. No

Section 2: Respondent profiling questions

1. What is your age (in years)?  
   98: Don’t know    99: Refused  
   Probe: If necessary, ask to see the birth certificate or the ID card.

2. Do you have a birth certificate?  
   1. Yes    2. No

3. How many children less than 3 years do you have? Please list the children, and provide us with the gender, date of birth, place of birth, if the child has or not a birth certificate, and if the child was born in a health facility.

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Child 2</th>
<th>Child 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Child's name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 Child’s gender</td>
<td>1. Male</td>
<td>2. Female</td>
</tr>
<tr>
<td>3.3 Child's DOB: dd/mm/yy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4 Child’s age (in months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 Child’s birth place (village)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.6 Possession of birth certificate</td>
<td>1. Yes</td>
<td>2. No</td>
</tr>
<tr>
<td>3.7 Born in a health facility</td>
<td>1. Yes</td>
<td>2. No</td>
</tr>
</tbody>
</table>

4. What is your ethnic group?  
   4.1. If other, please specify.  |

5. What is your highest level of education?  

6. Can you read and/or write in any language?  
   1.Yes    2. No
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReSt) 2016-2019

7. How many persons live in your household: Total number of members
   Number of children less than 5 years old ______________________
   Number of children aged 6-23 months ______________________

Section 3. Main employment and income generating activities

8. Have you been employed or involved in any income generating activity in the last 12 months?
   1. Yes  2. No

*If answer is no, skip to question 9.*

8.1 In which type of income generating activity/employment?

8.2 If other, please specify. ______________________

9. What about the head of your household, in which type of income generating activity or employment is the head of your household involved in?

9.2 If other, please specify. ______________________

10. During the last 24 months, were you able to make any savings?
    1. Yes  2. No

11. During the last 24 months, did you open a bank account?
    1. Yes  2. No

12. During the last 12 months, did you buy any productive assets?
    1. Yes  2. No

*If answer is no, skip to question 13.*

12.1 If yes, which one?
   1. Livestock  2. Garden/land  3. Other

12.2 If other, please specify. ______________________

Section 4: Questions on feeding practices and use of health services

13. How did you feed your (Name of Child) in the first six (6) months?
    1. Breastfeeding exclusively
    2. Both breastfeeding and feeding other foods/drinks
    3. Feeding my baby with breast milk substitutes only

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Child 2</th>
<th>Child 3</th>
</tr>
</thead>
</table>

14. Other than breast milk did (Name of Child) eat any solid, semi-solid, or soft foods since this time yesterday during the day or at night?
    1. Yes  2. No
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

If no for all children, skip to question 18.

15. **IF'YES' PROBE**: What kind of solid, semi-solid, or soft foods does your child eat? *(Circle all that apply).*
   1. Any food made from grain (e.g. Rice, Bread, Sorghum, Millet, Coos "chereh")
   2. Pumpkin (Squash), carrots, or orange sweet potatoes?
   3. Any other food made from roots or tubers (e.g. Irish Potatoes, Cassava)?
   4. Any dark green leafy vegetables (e.g. pumpkin leaves, sweet potato/ cassava leaves, spinach)
   5. Ripe mango, or paw-paws (papaya)
   6. Any other fruits and vegetables (e.g. Bananas, Orange, Pineapple, Avocados, Tomatoes?)
   7. Meat (beef, goat), poultry (chicken), fresh or dried fish
   8. Eggs
   9. Any food made from legumes (e.g. Beans, Soybeans, Lentils, Cowpeas, Ground Nuts)
   10. Cheese or yoghurt Milk (Dairy products)
   11. Vegetable oil, Palm oil, any fat, oil, butter
   12. Commercially iron fortified food/cereals (infant cereals) such as Cerelac

16. When did you start to feed the baby with other foods and drinks? Please give the age of the child in months.

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Child 2</th>
<th>Child 3</th>
</tr>
</thead>
</table>

17. How many times did (Name of Child) eat solid, semi-solid, or soft foods other than liquids yesterday during the day or at night? (Other than breast milk)

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Child 2</th>
<th>Child 3</th>
</tr>
</thead>
</table>

   1. 1-2 times/day
   2. 3-4 times/day
   3. 5 times/day particularly if the child is over one year

18. Have you ever received any counselling or messages on infant and young child feeding practices or other key family practices?

   1. Yes    2. No

   *If answer is no, skip to question 20.*

19.1. On what were you counselled on? *(Circle all that apply.)*

   1. Exclusive Breast Feeding (EBF)
2. Personal hygiene (hand washing practices)
3. Timely and appropriate complementary feeding
4. Safe drinking water
5. Importance of vaccination
6. Regular growth monitoring and promotion
7. Using Family Planning
8. Others
19.2. Please specify if others. 

19.3. Who provided the counselling? (Circle all that apply.)
1. Health facility workers at the health facility
2. Health facility workers during the reproductive and child health outreaches
3. An NGO
4. Radio
5. Other
19.4. Please specify if other. 

19.5. How many sessions in total have you attended in the past 12 months?
1. 1-3 Sessions
2. 4-6 Sessions
3. 7-9 Sessions
4. 10-12 Sessions

20. When did (name of the child) receive Vitamin A supplement the last time (mm/yy)?
98: Never 99: Don’t know

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Child 2</th>
<th>Child 3</th>
</tr>
</thead>
</table>

Probe: Ask the respondent if you can see the Infant Welfare Card of the child, and check the answer.

21. When did (name of the child) was dewormed the last time (mm/yy)?
98: Never 99: Don’t know

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Child 2</th>
<th>Child 3</th>
</tr>
</thead>
</table>

Probe: Ask the respondent if you can see the Infant Welfare Card of the child, and check the answer.

22. Do you have children aged between 36 to 59 months?
1. Yes  2. No

If no, skip to question 23.

22.1 Did any of them receive Vitamin A supplement in the last 6 months? 
1. Yes  2. No

22.2. Was any of them dewormed in the last 6 months? 
1. Yes  2. No
Section 5: Questions on WASH

23. Where do you get drinking water most of the time for your household during rainy season?
   1. Tap (own, neighbor, community)
   2. Protected well or source
   3. Unprotected source or river
   4. Rain water
   5. Unprotected well
   6. Other

23.1. If other, please specify.

24. Where do you get drinking water most of the time for your household during dry season?
   1. Tap (own, neighbor, community)
   2. Protected well or source
   3. Unprotected source or river
   4. Rain water
   5. Unprotected well
   6. Other

24.1. If other, please specify.

25. Do you treat your drinking water?
   1. Yes    2. No

   If answer is no, skip to question 23.

25.1. How do you treat your drinking water?
   1. Boil
   2. Add bleach/chlorine
   3. Strain it through a cloth
   4. Use a water filter (ceramic, sand, composite, etc.)
   5. Solar disinfection
   6. Let it stand and settle
   7. Other

25.2. If other, please specify.

26. Do you have a detergent to wash the hands in your dwelling?

   Cite the different types of detergent if the respondent needs it: a piece of, powdered or liquid soap, ashes/sand or any other detergent
   1. Yes    2. No

   Enumerator’s observations on the presence of soap or any other detergent in the household:

27. When do you typically wash your hands? (Circle all that apply.)
   1. After defecation
2. After cleaning a baby’s bottom after the baby has defecated
3. Before eating
4. Before feeding a child
5. Before cooking, cutting or preparing food
6. Never
7. Other.
27.1. If other, please specify.

28. What type of sanitation facilities do your household members use?
   1. Modern toilet
   2. Pit latrine
   3. VIP latrine
   4. None
   5. Other
28.1. If other, please specify.

Evaluator’s observations on sanitation facilities:

29. Do you dispose of children’s stools in the same sanitation facilities used by other household members?
   1. Yes.   2. No
   If answer is yes, skip to question 29.2.
29.1. If no, please indicate where do you dispose of children’s stools.
29.2. When your child is sick, where do you dispose of the stool?
   1. In the same place   2. Elsewhere
29.3. If elsewhere, please specify.

Section 6: Measurement of the MUAC
30. Now I am going to measure (name of the child)’s Mid Upper Arm Circumference. Measurement of the MUAC (in cm):

<table>
<thead>
<tr>
<th>Child 1</th>
<th>Child 2</th>
<th>Child 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thanks the respondent and close the interview.
I confirm that the questionnaire is fully completed.

Evaluator’s observations:
End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

Signature of enumerator
Annex 17. Planning of mission I

<table>
<thead>
<tr>
<th>Date</th>
<th>Institutions to meet</th>
<th>Propose time</th>
<th>Consultants team</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEETINGS IN BANJUL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday, 28/10/19</td>
<td><strong>Briefing at UNICEF CO</strong></td>
<td>9:00 – 10:30</td>
<td>M. Isaurralde &amp; A. Traoré &amp; Rohey John</td>
<td>Omar Jallow: 9271013</td>
</tr>
<tr>
<td></td>
<td><strong>Ministry of Health</strong></td>
<td>11:00 – 12:00</td>
<td>Aminata Traoré and local researcher</td>
<td>Fanta Bai Secka – Deputy Permanent Secretary 3185809</td>
</tr>
<tr>
<td></td>
<td><strong>National Assembly Select Committee on children, health and refugees</strong></td>
<td>12:15 – 13:15</td>
<td>Aminata Traoré and local researcher</td>
<td>Daniel Cardos – Deputy Clerk 9967756</td>
</tr>
<tr>
<td></td>
<td><strong>NaNA (Data analyst and IT specialist)</strong></td>
<td>12:00 – 13:00</td>
<td>S. Satriana &amp; M. Isaurralde</td>
<td>Malang Fofana – BReST project Facilitator 9975566</td>
</tr>
<tr>
<td></td>
<td><strong>European Union Delegation</strong></td>
<td>16:00 – 17:00</td>
<td>The 4 team members</td>
<td>Darrell Sexstone – Programme Manager 7900085</td>
</tr>
<tr>
<td>Friday, 1/11/2019</td>
<td><strong>Training of local partner for the quantitative data collection</strong></td>
<td>10:00 – 16:00</td>
<td>Aminata</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>PMT (DSW &amp; NaNA)</strong></td>
<td>09:00 – 11:00</td>
<td>M. Isaurralde &amp; S. Satriana</td>
<td>Malang Fofana – BReST project Facilitator 9975566</td>
</tr>
<tr>
<td></td>
<td><strong>Debriefing at UNICEF CO</strong></td>
<td>14-16</td>
<td>The 4 team members</td>
<td></td>
</tr>
<tr>
<td><strong>MEETINGS IN URR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday, 29/10/19</td>
<td><strong>Regional Health Director (based in Basse)</strong></td>
<td>12:00 – 13:30</td>
<td>Magdalena Isaurralde and local team</td>
<td>Lamin Ceesay – Regional Director 3509026</td>
</tr>
</tbody>
</table>
### End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Activity</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday, 30/10/19</td>
<td>13:30 – 15:00</td>
<td>Magdalena Isaurralde and local team</td>
<td>Kebba Jatta – Regional Social Welfare Officer 7777061</td>
</tr>
<tr>
<td></td>
<td>15:30 – 17:00</td>
<td>Magdalena Isaurralde and local team</td>
<td>Saikou Drammeh NaNA NFO 3011313</td>
</tr>
<tr>
<td>Regional social workers</td>
<td>13:30 – 15:00</td>
<td>Magdalena Isaurralde and local team</td>
<td>Kebba Jatta – Regional Social Welfare Officer 7777061</td>
</tr>
<tr>
<td>NaNA Nutrition Field Officer</td>
<td>15:30 – 17:00</td>
<td>Magdalena Isaurralde and local team</td>
<td>Saikou Drammeh NaNA NFO 3011313</td>
</tr>
<tr>
<td>Wednesday, 30/10/19</td>
<td>9:00 – 10:00</td>
<td>Magdalena Isaurralde and local team</td>
<td>Saikou Drammeh NaNA NFO 3011313</td>
</tr>
<tr>
<td>Policy meeting with Governor</td>
<td>9:00 – 10:00</td>
<td>Magdalena Isaurralde and local team</td>
<td>Saikou Drammeh NaNA NFO 3011313</td>
</tr>
<tr>
<td>OIC and Community health nurses in Basse Health Facility</td>
<td>10:30 - 12:00</td>
<td>Magdalena Isaurralde and local team</td>
<td>Lamin Ceesay – Regional Director 3509026</td>
</tr>
<tr>
<td>FGD with the Basse VDC</td>
<td>12:30 – 14:00</td>
<td>Magdalena Isaurralde and local team</td>
<td>Saikou Drammeh NaNA NFO 3011313</td>
</tr>
<tr>
<td>FGD with the Basse VSG</td>
<td>15:00 – 16:30</td>
<td>Magdalena Isaurralde and local team</td>
<td>Saikou Drammeh NaNA NFO 3011313</td>
</tr>
<tr>
<td>Thursday, 31/10/19</td>
<td>9:00 – 10:30</td>
<td>Magdalena Isaurralde and local team</td>
<td>Lamin Ceesay – Regional Director 3509026</td>
</tr>
<tr>
<td>OIC and Community health nurses in Demba Kunda Health Facility</td>
<td>9:00 – 10:30</td>
<td>Magdalena Isaurralde and local team</td>
<td>Lamin Ceesay – Regional Director 3509026</td>
</tr>
<tr>
<td>FGD with Demba Kunda VDC</td>
<td>11:00 – 12:30</td>
<td>Magdalena Isaurralde and local team</td>
<td>Saikou Drammeh NaNA NFO 3011313</td>
</tr>
<tr>
<td>FGD with Demba Kunda VSG</td>
<td>12:30 – 14:30</td>
<td>Magdalena Isaurralde and local team</td>
<td>Saikou Drammeh NaNA NFO 3011313</td>
</tr>
</tbody>
</table>

### MEETINGS IN NBR

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Activity</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday, 29/10/19</td>
<td>8:30 – 9:30</td>
<td>Sinta Satriana and local team</td>
<td>Modou Lamin Manneh Regional Health Director 3509024</td>
</tr>
<tr>
<td>Regional Health Director NBW (based in Essau) (Please include a meeting with the Essau health Facility OIC, CHN)</td>
<td>8:30 – 9:30</td>
<td>Sinta Satriana and local team</td>
<td>Modou Lamin Manneh Regional Health Director 3509024</td>
</tr>
<tr>
<td>NaNA regional coordinator</td>
<td>9:45 – 10:45</td>
<td>Sinta Satriana and local team</td>
<td>Alpha Mballow – Nutrition Field Officer 3871792</td>
</tr>
<tr>
<td>Regional social workers</td>
<td>11:00 – 12:00</td>
<td>Sinta Satriana and local team</td>
<td>Alhassan Sanneh Regional Social Worker - 3521119</td>
</tr>
</tbody>
</table>
## End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Time</th>
<th>Participants</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday, 30/10/19</td>
<td>FGD with Essau VDC</td>
<td>12:30 – 14:00</td>
<td>Sinta Satriana and local team</td>
<td>Alpha Mballow – Nutrition Field Officer 3871792</td>
</tr>
<tr>
<td></td>
<td>FGD with Essau VSG</td>
<td>15:00 – 16:30</td>
<td>Sinta Satriana and local team</td>
<td>Alpha Mballow – Nutrition Field Officer 3871792</td>
</tr>
<tr>
<td></td>
<td>OIC and Community health nurses in Kuntair Health Facility</td>
<td>9:00 – 10:00</td>
<td>Sinta Satriana and local team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FGD with Kuntair VDC</td>
<td>10:15 – 12:15</td>
<td>Sinta Satriana and local team</td>
<td>Abdoulie Jarju – Regional Health Director</td>
</tr>
<tr>
<td></td>
<td>FGD with Kuntair VSG</td>
<td>12:30 - 13:30</td>
<td>Sinta Satriana and local team</td>
<td>Modou Lamin Manneh Regional Health Director 3509024</td>
</tr>
<tr>
<td></td>
<td>Meeting with Policy Maker in NBR – Governor in Kerewan</td>
<td>14:30 – 15:15</td>
<td>Sinta Satriana and local team</td>
<td>Alpha Mballow – Nutrition Field Officer 3871792</td>
</tr>
<tr>
<td></td>
<td>Meeting with NBRE RHD</td>
<td>16:00 – 17:00</td>
<td>Sinta Satriana and local team</td>
<td>Alpha Mballow – Nutrition Field Officer 3871792</td>
</tr>
<tr>
<td>Thursday, 31/10/19</td>
<td>OIC and Community health nurses in N’Gayen Sanjal Health Facility</td>
<td>9:00 – 10:30</td>
<td>Sinta Satriana and local team</td>
<td>Abdoulie Jarju – Regional Health Director</td>
</tr>
<tr>
<td></td>
<td>FGD with N’Gayen Sanjal VDC</td>
<td>11:00 – 12:30</td>
<td>Sinta Satriana and local team</td>
<td>Bubab Jatta – NaNA Nutrition Field Officer – 3505171</td>
</tr>
<tr>
<td></td>
<td>FGD with N’Gayen Sanjal VSG</td>
<td>12:30 – 14:00</td>
<td>Sinta Satriana and local team</td>
<td>Bubab Jatta – NaNA Nutrition Field Officer – 3505171</td>
</tr>
<tr>
<td><strong>MEETINGS IN CRR</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday, 29/10/19</td>
<td>OIC and Community health nurses in Kudang Health Facility</td>
<td>10:00 – 11:30</td>
<td>Aminata Traoré and local team</td>
<td>Baba Galeh Jallow Regional Health Director 3929537</td>
</tr>
<tr>
<td></td>
<td>OIC and Community health nurses in Brikamaba Health Facility</td>
<td>12:30 – 14:00</td>
<td>Aminata Traoré and local team</td>
<td>Baba Galeh Jallow Regional Health Director 3929537</td>
</tr>
<tr>
<td></td>
<td>Regional Health Director in Bansang</td>
<td>15:00 – 16:00</td>
<td>Aminata Traoré and local team</td>
<td>Baba Galeh Jallow Regional Health Director 3929537</td>
</tr>
</tbody>
</table>
## End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Time</th>
<th>Participants</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday, 30/10/19</td>
<td>Policy meeting with Governor in Janjanbureh</td>
<td>9:00 – 10:00</td>
<td>Aminata Traoré and local team</td>
<td>Baba Galeh Jallow Regional Health Director 3929537</td>
</tr>
<tr>
<td></td>
<td>OIC and Community health nurses in Kuntaur Health Facility</td>
<td>11:00 – 12:00</td>
<td>Aminata Traoré and local team</td>
<td>Baba Galeh Jallow Regional Health Director 3929537</td>
</tr>
<tr>
<td></td>
<td>FGD with Kuntaur VDC</td>
<td>12.30 – 14.00</td>
<td>Aminata Traoré and local team</td>
<td>Mafugi Jawara – NaNA NFO 3014668</td>
</tr>
<tr>
<td></td>
<td>FGD with Kuntaur VSG</td>
<td>14.40 – 16.00</td>
<td>Aminata Traoré and local team</td>
<td>Mafugi Jawara – NaNA NFO 3014668</td>
</tr>
<tr>
<td>Thursday, 31/10/19</td>
<td>NaNa regional coordinator in Janjanbureh</td>
<td>09:00 – 10:30</td>
<td>Aminata Traoré and local team</td>
<td>Mafugi Jawara – NaNA NFO 3014668</td>
</tr>
<tr>
<td></td>
<td>Regional social worker in Janjanbureh</td>
<td>10:30 – 12:00</td>
<td>Aminata Traoré and local team</td>
<td>Ebrima Jassey Regional Social Welfare Officer 9168294</td>
</tr>
<tr>
<td></td>
<td>FGD with Brikamaba VDC</td>
<td>13.00 – 14.00</td>
<td>Aminata Traoré and local team</td>
<td>Mafugi Jawara – NaNA NFO 3014668</td>
</tr>
<tr>
<td></td>
<td>FGD with Brikamaba VSG</td>
<td>14.30 – 16.00</td>
<td>Aminata Traoré and local team</td>
<td>Mafugi Jawara – NaNA NFO 3014668</td>
</tr>
</tbody>
</table>
Annex 18. Planning of mission II

**Banjul, the Gambia, from 1st to 8th December 2019**

The mission will be composed of Ms. Magdalena Isaurralde, Ms. Sinta Satrina, Ms. Aminata Bakouan Traoré’s replacement and Ms. Rohey John, our local partner. The international consultant team will arrive in Banjul on Saturday 30/11/2019 and Sunday 1/12/2019. Meeting in the 3 regions will be done simultaneously.

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Propose time</th>
<th>Detail</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday 1/12/2019</td>
<td>Meeting to discuss field logistics</td>
<td>12.00 noon</td>
<td>International and local team</td>
<td>Ms. Magdalena Isaurralde, Ms. Sinta Satrina, Ms. Aminata Bakouan Traoré’s replacement and Ms. Rohey John</td>
</tr>
<tr>
<td></td>
<td>Travel to the field</td>
<td>13.00</td>
<td>All</td>
<td></td>
</tr>
</tbody>
</table>

**Regional Research Team: URR**

<table>
<thead>
<tr>
<th>Role</th>
<th>Name &amp; Mobile Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Team Leader</td>
<td>Magdalena Isaurralde – local number: 5344740</td>
</tr>
<tr>
<td>Local Team Leader</td>
<td>Lamin Jaiteh - 7002958</td>
</tr>
</tbody>
</table>

**Field Assistants**

1. Ansu Ceesay – 7539559
2. Yusupha Manneh – 7690063/3080295
3. Modou Njie – 7885500
4. Abubacarr Banjo – 3033918
5. Adama Manneh - 2190286
6. Ebou Lowe - 7373169

**MEETINGS IN URR**

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Time</th>
<th>Detail</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, 2/12/19</td>
<td>FGD with women in Demba Kunda (Treatment group 10 participants)</td>
<td>9.30 – 11:00</td>
<td>Magdalena Isaurralde and local team</td>
<td>Village Alkalo (to be contacted)</td>
</tr>
</tbody>
</table>
### End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

#### FGD with men in Demba Kunda (Spouses of treatment, 10 participants)
- Date: Tuesday, 3/12/19
- Time: 12.00 – 13:30
- Facilitators: Magdalena Isaurralde and local team

#### FGD with women in Basse (Treatment group, 10 participants)
- Date: Tuesday, 3/12/19
- Time: 15:30 – 17:00
- Facilitators: Magdalena Isaurralde and local team

#### Tuesday 3/12/19
- FGD with men in Basse (Spouses of treatment group, 10 participants)
  - Time: 9.30 – 11.00
  - Facilitators: Magdalena Isaurralde and local team
- Travel to CRR (night stop)
  - Time: 14.30
  - Facilitators: Magdalena Isaurralde and local team

#### Wednesday, 4/12/19
- FGD with women in Kuntaur (Treatment group, 10 participants)
  - Time: 10:00 – 11:30
  - Facilitators: Magdalena Isaurralde and local team
  - Saikou Drammeh NaNA NFO 3011313
- FGD with men in Kuntaur (Spouses of treatment group, 10 participants)
  - Time: 12:30 - 14:00
  - Facilitators: Magdalena Isaurralde and local team
- FGD with men in Ngayen Sanjal (Spouses of treatment group, 10 participants)
  - Time: 15.30 – 17.00
  - Facilitators: Magdalena Isaurralde and local team
- Travel to Farafenni (night stop)
  - Time: 17.30
  - Facilitators: Magdalena Isaurralde and local team

#### Thursday, 5/12/19
- Travel to Banjul
  - Time: 8.30
  - Facilitators: Magdalena Isaurralde and local team

### Regional Research Team: NBR

<table>
<thead>
<tr>
<th>Name &amp; Mobile Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>International Team Leader</strong></td>
</tr>
<tr>
<td><strong>Local Team Leader</strong></td>
</tr>
</tbody>
</table>
| **Field Assistants (Second Mission)** | 1. Lamin Marena – 6840122  
  2. Jebbel Bah – 6291778  
  3. Kadijatou Susso – 3941991 |
<table>
<thead>
<tr>
<th>MEETINGS IN NBR</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday, 2/12/19</strong></td>
<td></td>
</tr>
<tr>
<td>FGD with women in Essau (Treatment</td>
<td>9.30 – 11:00 Sinta Satriana and local team</td>
</tr>
<tr>
<td>group, 10 participants)</td>
<td>Village Alkalo (to be contacted)</td>
</tr>
<tr>
<td>FGD with men in Essau (Spouses of</td>
<td>12.00 – 13:30 Sinta Satriana and local team</td>
</tr>
<tr>
<td>treatment, 10 participants)</td>
<td></td>
</tr>
<tr>
<td>FGD with women in Albreda (Treatment</td>
<td>15:30 – 17:00 Sinta Satriana and local team</td>
</tr>
<tr>
<td>group, 10 participants)</td>
<td></td>
</tr>
<tr>
<td>Night stop in Albreda</td>
<td>11:30 Sinta Satriana and local team</td>
</tr>
<tr>
<td><strong>Tuesday 3/12/19</strong></td>
<td></td>
</tr>
<tr>
<td>FGD with men in Albreda (Spouses of</td>
<td>9.30 – 11.00 Sinta Satriana and local team</td>
</tr>
<tr>
<td>treatment group, 10 participants)</td>
<td></td>
</tr>
<tr>
<td>FGD with women in Kuntaur (Treatment</td>
<td>12.30 – 14.00 Sinta Satriana and local team</td>
</tr>
<tr>
<td>group, 10 participants)</td>
<td></td>
</tr>
<tr>
<td>Travel to Kerewan for night stop</td>
<td>11.30 Sinta Satriana and local team</td>
</tr>
<tr>
<td><strong>Wednesday, 4/12/19</strong></td>
<td></td>
</tr>
<tr>
<td>FGD with men in Kuntaur (Spouses of</td>
<td>9.30 – 11.00 Sinta Satriana and local team</td>
</tr>
<tr>
<td>treatment group, 10 participants)</td>
<td></td>
</tr>
<tr>
<td>FGD with women in Ngayen Sanjal (</td>
<td>15.30 – 17.00 Sinta Satriana and local team</td>
</tr>
<tr>
<td>Treatment group, 10 participants)</td>
<td></td>
</tr>
<tr>
<td>Travel to Farefenni for night stop</td>
<td>17.30 Sinta Satriana and local team</td>
</tr>
</tbody>
</table>
Thursday, 5/12/19 | Travel to Banjul | 8.30 | Sinta Satriana and local team

**Regional Research Team: CRR**

<table>
<thead>
<tr>
<th>Name &amp; Mobile Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>International Team Leader</strong></td>
</tr>
<tr>
<td><strong>Local Team Leader</strong></td>
</tr>
<tr>
<td><strong>Field Assistants (Second Mission)</strong></td>
</tr>
<tr>
<td><strong>CRR Kuntaur Area</strong></td>
</tr>
<tr>
<td>1. Ousman Bajinka – 2365775</td>
</tr>
<tr>
<td>2. Jallamang Darboe – 6991984</td>
</tr>
<tr>
<td><strong>CRR South</strong></td>
</tr>
<tr>
<td>3. Ramatoulie Kandeh – 7275823</td>
</tr>
<tr>
<td>4. Seedy Saidykhan – 2482317</td>
</tr>
<tr>
<td>5. Muhammed Barrow – 3053576</td>
</tr>
<tr>
<td>6. Jakariya Camara - 3441092</td>
</tr>
</tbody>
</table>

**MEETINGS IN CRR**

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Time</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, 2/12/19</td>
<td>FGD with women in Dankunku (Treatment group, 10 participants)</td>
<td>10.00 – 11:30</td>
<td>New International member and local team</td>
</tr>
<tr>
<td></td>
<td>FGD with men in Dankunku (Spouses of treatment, 10 participants)</td>
<td>12.00 – 13:30</td>
<td>New International member and local team</td>
</tr>
<tr>
<td></td>
<td>Travel back to Janjangbureh for night stop</td>
<td>14.00</td>
<td>New International member and local team</td>
</tr>
<tr>
<td>Tuesday 3/12/19</td>
<td>FGD with women in Brikama Ba (Treatment group, 10 participants)</td>
<td>10.00 – 11.30</td>
<td>New International member and local team</td>
</tr>
</tbody>
</table>
### End of Project evaluation: Building resilience for nutritional security in the Gambia through Social Transfers (BReST) 2016-2019

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Time</th>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wednesday 4/12/19</strong></td>
<td>FGD with women in Kudang (Treatment group, 10 participants)</td>
<td>10.00 – 11.30</td>
<td>New International member and local team</td>
</tr>
<tr>
<td></td>
<td>FGD with men in Kudang (Spouses of treatment group, 10 participants)</td>
<td>12.30 – 14.00</td>
<td>New International member and local team</td>
</tr>
<tr>
<td></td>
<td>Travel to Jarra Soma for night stop</td>
<td>14.30</td>
<td>New International member and local team</td>
</tr>
<tr>
<td><strong>Thursday, 5/12/19</strong></td>
<td>Travel to Banjul</td>
<td>8.30</td>
<td>New International member and local team</td>
</tr>
<tr>
<td><strong>Friday, 6/12/19</strong></td>
<td>Briefing at UNICEF CO</td>
<td>9:00 – 10:30</td>
<td>M. Isaurralde &amp; Team</td>
</tr>
<tr>
<td></td>
<td>Meeting at the office of the Vice President</td>
<td>11.30 – 12.30</td>
<td>M. Isaurralde &amp; Team</td>
</tr>
<tr>
<td></td>
<td>Briefing by all teams</td>
<td>15.00 – 17.00</td>
<td>All 3 teams</td>
</tr>
</tbody>
</table>