Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 28-Feb-2018 | Report No: PIDISDSA23339

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Guinea-Bissau	P163954	Strengthening Maternal and Child Health Service Delivery in Guinea-Bissau	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	21-Feb-2018	08-May-2018	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Economy and Finances	Ministry of Public Health	

Proposed Development Objective(s)

To improve utilization of essential maternal and child health services in Guinea-Bissau.

Components

1 - Institutional Strengthening of the Ministry of Public Health
2 - Health Workforce Development
3 - Performance-based financing to deliver a package of essential maternal and child health services
4 - Community Health

Financing (in USD Million)

Financing Source	Amount
International Development Association (IDA)	25.00
Total Project Cost	**25.00**

Environmental Assessment Category

B - Partial Assessment

Decision

The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. Guinea-Bissau, the 12th poorest country in the world, has faced continuous political instability, poverty and poor human development outcomes since its independence in 1973. With a Gross National Income (GNI) per capita of US$620 (2016), around 70% of the population lives in moderate poverty (PPP US$2 per day) and about 33% in extreme poverty (PPP $1 per day).[1] Guinea-Bissau ranks 178th out of 188 countries of the 2016 Human Development Report. The country's Human Development Index (HDI) is 0.420, which is below the average among countries in the low human development category (0.497) and well below the average among countries in Sub-Saharan Africa (0.523).[2] The population of Guinea-Bissau is estimated at 1.8 million (2016) of which around 50% lives in urban areas, most in the capital Bissau.[3] The majority of the population, particularly the rural poor, has limited access to basic goods and services that directly influence the wellbeing of households. Poverty rates are higher in rural Guinea-Bissau (76%) than in the capital Bissau (51%).

2. The economy is dominated by agriculture, accounting for over 40% of gross domestic product (GDP) and employing about 80% of the workforce. The production and export of raw cashews nuts constitute the main source of income for more than two thirds of households (and for virtually all small farmers) and represent over 85% of the country's total export earnings. In contrast with the trends in most of the countries in the region, manufacturing contributes to approximately 16 percent of GDP. The country has experienced strong economic growth in the recent years with an average GDP growth of 4.3% between 2014 and 2016 (5.6% in 2016), influenced by increased prices and demand for cashew on the international markets. Despite the good economic prospects and the associated increased in tax revenues, the fiscal deficit continues to be a challenge at 4.2% of GDP in 2016. Tax revenues as a proportion of GDP amounts to only 10% (2016), ranking among the lowest performers in Sub-Saharan Africa. The economy is characterized by a high level of vulnerability to external developments due to the dependence on a single export (cashew). Binding constraints on growth include, among others, chronic underinvestment in infrastructure and human capital.[4]

3. Ongoing political instability imposes large costs on economic and social development in the country. Since its independence in 1973, there have been many coup attempts and four successful ones. Following the most recent *coup d'état* in 2012, Guinea-Bissau underwent a period of political transition, with general elections successfully held in 2014. A short-lived period of political stability after the elections fostered important steps toward a set of reforms. However, political tensions emerged again in mid-2015 and continue until today. Political instability and fragility is also manifested in the frequent government turnovers. Between 1999 and 2009, there was a change of government every year and in the last 18 months the country has had four governments. Instability has led to a weak State and institutions

[1] World Bank, 2015. Poverty Mapping Report.
[2] UNDP, 2016. Human Development Report 2016. Briefing note for countries (Guinea-Bissau).
[3] World Development Indicators, 2016.
[4] CEM, 2014.

and Guinea-Bissau scores in the bottom 10th percentile on all indicators measuring public sector capacity in the World Bank's Worldwide Governance Indicator (WGI). Fragility has led to weak governance, which results in limited provision of basic public goods and services and high economic costs – after the last coup the economy contracted by 1.8% in 2012 and barely recovered in 2013.

Sectoral and Institutional Context

4. Guinea-Bissau meets many if not all the criteria that characterize health systems in fragile states. The country's health system faces persistent challenges related to low public spending, poor infrastructure, inadequate supply of health workers, inadequate clinical and managerial training systems, malfunctioning referral system, non-operational health-information systems, weak governance and inadequate management capacity and systems (such as budgeting, public financial management and human resources management). Public spending accounts for about 20% of total health spending and is mostly used to pay staff salaries, while donors finance nearly 90% of the recurrent costs of the sector, including medicines and other critical health inputs.

5. The country faces persistent challenges in the health sector with high burden of infection diseases and high rates of child mortality. The country's life expectancy is 55 years, which is lower than the average for Guinea-Bissau's regional (59) and income peers (60). Malaria is the single biggest cause of deaths (15.8%), followed by HIV/AIDS, neonatal disorders, lower respiratory infections, diarrheal diseases and nutritional deficiencies. The burden of HIV in Guinea-Bissau is the highest in West Africa and it disproportionately affects more women than men (female adults with HIV represents 58.6% of the population above 15 years old with HIV).[5] Progress has been made to reduce infant mortality, but both infant mortality rate (IMR) and under-five mortality rate (U5MR) remain among the highest in the world, 60 and 88.8 per 1,000 live births, respectively.

6. Guinea-Bissau has one of the highest maternal mortality rates in the world. According to the last Multi Indicators Cluster Survey (MICS) the maternal mortality rate (MMR) is estimated at 900 maternal deaths per 100,000 live births, which is higher than the average among West Africa countries (579), among other low-income countries (542) and in Sub-Saharan Africa (494). The country did not achieve the Millennium Development Goal (MDG) for maternal health, set to lower MMR to 229 per 100,000 live births and is unlikely to achieve the Sustainable Development Goals (SDGs) target for 2030 along the current trend.[6]

7. Neonatal mortality rate (NMR), 35.8 per 1,000 live births, is higher than the average for West Africa and is strongly associated with birth spacing and birth order, indicating a lack of access to reproductive health services. The rate of NMR is comparable for any of the first six children born to a woman (approximately 36 per 1000 live births), but is 2.5 times higher for children born seventh or later in the birth order. This pattern is also true for birth spacing; children born less than two years after their previous sibling are almost twice as likely to die as if they were born at least three years after their previous sibling. These same patterns hold true for U5MR, currently at 89 per 1000 live births.[5] Given constraints in the access pointed out above, birth spacing and maternal knowledge seem to be more important factors influencing child health outcomes. Unsurprisingly, only 16% of women aged 15-49 report using any

[5] World Bank, 2016. Guinea-Bissau Health Sector Diagnostic. World Bank, Washington, DC.
[6] World Development Indicators, 2016.

contraceptive method,[7] and the adolescent pregnancy rate is estimated at 28%.

8. The utilization of obstetric services by expecting mothers in Guinea-Bissau is significantly low. Only 45% of the deliveries take place within health facilities.[5] A recent assessment by a European Union funded health project showed only 38% of women had the standard four antenatal consultations and that out of every 100 women having at least one antenatal care visit only 37% delivered their babies in a health facility.[8] In addition, there is large variation in burden of maternal and child health deaths distribution within Guinea-Bissau. U5MR, for example, varies from 41.8 per 1,000 in the region of Biombo to 158.9 per 1,000 in Gabú and 125.6 per 1,000 in Bafatá (Table 1). When looking across regions, Gabú and Bafatá consistently underperform in nearly all potential factors child health outcomes.

Table 1: Extreme Poverty and Maternal and Child Health Indicators, Guinea-Bissau regions (2014)

Region	Extreme Pov. Rate*	NMR**	U5MR**
Bissau	0.17	33.5	68.7
Bolama	0.23	36.4	75
Biombo	0.37	11.5	41.8
Tombali	0.41	38.3	82.4
Bafatá	0.41	45.7	125.6
Gabú	0.43	49.5	158.9
Cacheu	0.45	43	95.7
Oio	0.5	30.4	63.7
Quinara	0.51	19.9	76.8
Guinea-Bissau	**0.33**	**35.8**	**88.8**

Source: World Bank, 2016 and MICS, 2015.
* Extreme Poverty Rate is the proportion of people who live on < $1 per day (PPP);
** NMR and U5MR are per 1,000 live births.

9. Guinea-Bissau has a very high burden of malnutrition, which directly correlates with maternal and child mortality. Per a national food security assessment conducted by the World Food Programme (WFP) in 2013, only 7% of the population in Guinea-Bissau is food secure. The level of food insecurity is particularly high in rural areas at 93% and requires immediate assistance.[9] Food insecurity leads to malnutrition, which is a public health challenge of major concern. Indeed, the national prevalence of acute malnutrition (wasting, defined as weight for height lower than two standard deviations below the mean) is 6% overall, reaching approximately 8% in some areas, while the prevalence of stunting among children

[7] MICS 2015
[8] PIMI Report. European Union, 2016.
[9] World Food Programe, 2013. Synthesis of Rapid Food Security Assessment. Bissau, Guinea-Bissau.

under five years is 27.6%.[10] Moreover, Guinea-Bissau has a higher burden of deaths and DALYs due to nutritional deficiencies compared to structural and regional peers. There is strong evidence showing that malnutrition is perhaps the single greatest cause of child mortality in developing countries, as malnutrition weakens a child's ability to recover from a disease that would otherwise not kill a well-nourished child.[11] Malnutrition also contributes to the high-rates of anemia among women, which put pregnant women at increased risk for hemorrhage and other birth complications.

Health Financing

10. As a percentage of GDP, the level of health spending in Guinea-Bissau is comparable to its regional and economic peers, but the composition of its spending is highly problematic. Total health expenditure (THE) in Guinea-Bissau represents 5.6% of its GDP, which is close to the average of its regional (5.8%) and economic peers (5.7%). However, the country relies more on out-of-pocket (OOP) payments and external resources to fund health services. Neither of these is a desirable means to secure financial protection and of revenue collection: high OOP payments increases the risk of exposing households to financial shocks associated with ill health, and a continuous dependence on external resources has implications for sustainable health financing, while it also limits Guinea-Bissau's ability to plan systematically for the long term.[12,13] In terms per capita, health spending (US$37) is well below the average per capita among West African countries (US$65.3) and approximately a third of the Sub-Saharan African countries average (US$97). This is largely driven by low public health spending, which accounts for only 20% of THE, or 7.8% of total government spending (2014 figures).

11. Despite the limited public health spending, the Ministry of Public Health (MINSAP) has not been able to entirely execute its budget. The MINSAP budget execution was approximately 50% in 2014 and decreased to 42% in 2015. The only category with high execution was staff costs (93% in 2014 and 79% in 2015). The low execution rates indicate the limited government capacity to strategically plan and implement health policy actions. Additionally, no Public Financial Management System (PFM) system is in place. Comprehensive data on resources received by health facilities are lacking. Patients generally pay consultations, for drugs and other medical procedures. Most these OOP payments are managed at facility level for maintenance of the facility and purchase health care goods (mostly drugs). There is little data to indicate the true volume of these payments and the use to which these are being put, given that the entire system is essentially informal. Even in respect of use of central health care funds, there is no record of all health care expenditure, particularly the funds that are not used to pay staff salaries.[14]

12. Households bear a high proportion of total health expenditures in Guinea-Bissau. A recent World Bank report shows that households spend on average 15% of their non-food expenditures on health care, with lower income groups spending a larger proportion of their household income on health than the highest income group.[15] OOP payments are not associated with improved access to health services:

[10] UNICEF, 2015. Multi Indicators Cluster Survey.
[11] Benson T and Shekar M, 2006. Trends and Issues in Child Undernutrition. Chapter 8. In: Jamison DT, Feachem RG, Makgoba MW, et al., editors. Disease and Mortality in Sub-Saharan Africa. 2nd edition. Washington (DC).
[12] (Ke Xu et al., 2003)
[13] (Gottret and Schieber, 2006
[14] UNIOGBIS, 2017.Thematic report on the right to health in Guinea-Bissau. UN HR, Bissau, Guinea-Bissau.
[15] World Bank, 2016. Guinea-Bissau Health Sector Diagnostic. World Bank, Washington, DC.

households in Gabú and Bafatá spend more on health care through OOP payments and face higher-than-average rates of neonatal and child mortality. Approximately 12% of the households incurred catastrophic health expenditures. The incidence of catastrophic payments is higher in Gabú, Bolama and Biombo, and catastrophic payments are more common among households in rural areas (16%) than in urban areas (11.3%). Payments for health care increase the absolute and extreme poverty headcount ratio by 1.4 and 1.1 percentage points. It means health care payments push more households into poverty and deepen the poverty of the already poor.[16] Every year in Guinea-Bissau approximately 15,000 people are pushed into extreme poverty due to health care payments.

Health Service Delivery

13. Health service delivery in Guinea-Bissau is structured around 11 sanitary regions, and organized in local, regional and central levels.[17] The local level is divided between 114 sanitary areas, which are the primary locus for implementation of primary health care (PHC) activities through 132 health centers. The regional level provides technical support and coordination for the sanitary areas. This level contains an administrative structure, the regional health directorates (DRS, *Direção Regional de Saude*), and technical units such drugs warehouses, diagnostic centers, and secondary level regional hospitals. The central level is responsible for setting health policies, strategies and regulations. At this level are the National Hospital (*Hospital Nacional Simão Mendes*), specialized hospitals (for conditions such as tuberculosis and mental health) and satellite health centers. PHC facilities are classified into three types of health centers (A, B, and C), distinguished by their capacity to deliver complex health interventions. Health centers type A, for example, are defined by the capacity to perform surgeries, and they are in sanitary regions where there are no regional health hospitals. The PHC centers are responsible for the implementation of the minimum benefits package (PMA, *Pacote Minimo de Atividades)*, defined by the Ministry of Public Health (MINSAP), which is composed of five groups of activities: curative, preventive, population health (communication and health promotion), outreach activities, and support services (diagnostics, referral).

Figure 2: Organization of Guinea-Bissau Public Health Care Delivery System

Regions	Population (2017)	Regional Hospital	MCH Center	Health Centers			Total Health facility	ASCs (Estimative)
				Type A	Type B	type C		
Bafata	217,045	1	1	-	1	12	13	574
Gabu	259,570	1	1	-	1	17	18	587
Cacheu	229,204	1	2	1	1	17	19	529
Bolama	11,510	-	-	1	-	4	5	29
Bijagos	24,007	-	-	1	-	10	11	68
Oio	180,428	1	-	-	1	8	9	615
SAB	513,846	-	1	-	3	6	9	1,043
Farim	58,060	-	-	1	1	4	6	141
Quinara	77,465	-	-	1	3	10	14	174

[16] The headcount ratio is the proportion of a population that exists, or lives, below the poverty line.
[17] Republica da Guinea-Bissau, 2008. Plano Nacional de Desenvolvimento Sanitário. Ministerio da Saúde Publica. Bissau, Guinea-Bissau.

Tombali	116,994	1	-	-	2	19	21	260
Biombo	54,507	-	-	-	1	6	7	267
Total	**1,742,636**	**5**	**5**	**5**	**14**	**113**	**132**	**4,287**

Source: MINSAP, 2017.

Access to health care

14. Health care costs and distance to health providers were reported as the main reasons for not seeking health care when needed. On average, 44% of the ILAP II respondents were discouraged to seek treatment by health care costs when falling ill. Surprisingly, the percentage of those reporting costs as the main barrier is higher for the richest group (39%) than for the poorest group (35%). Across regions, there was no evidence that relatively better-off regions have more affordable healthcare. The percentage of those reporting health care costs as the main barrier to seeking care was higher than the national average in Cacheu (58%), Bissau (51%) and Gabú (51%). The second main reason for not seeking care providers was distance from respondents' home (10.5%). For example, 52% of Bissau-Guineans travel for over an hour to reach the nearest health care facility, which is usually a 'type C' facility providing only the most basic health care interventions.[18] Regarding health care providers' location convenience, Quinara (26%), Oio (21%), and Bolama (20%) reported the highest rate of complaints.

Health Workforce

15. The country's health system faces persistent challenges related to the inadequate supply and maldistribution of health workers. The public health sector currently officially employs 2,173 workers in Guinea Bissau, of which 264 physicians and 1,027 nurses. In relation to the served population, there were 1.7 physicians and 11.5 health workers per 10,000 inhabitants in 2016. Over the recent years, the impact of the war-related diaspora on the workforce has been noticeable, particularly in terms of the loss of skilled cadres between 1996 and 2007 (Table). Although on balance the health workforce has been relatively stable during the last two decades, progress has been registered in terms of the upgrade of auxiliary health personnel, and of the reduction of support staff in favor of training general nurses and physicians.[19] In 2016, 60% of all health workers were female, although women represented only 31% of physicians.

Table 2: Evolution of the health workforce between 1996 and 2016, by categories

Category	1996	2007	2016
Physicians	165	104	264
Nurses	357	300	1,027
Midwives	67	177	141
Technical staff	276	199	244
Support	417	642	98
Other (aux.)	1,043	696	399
Total	**2,325**	**2,118**	**2,173**

[18] UNIOGBIS, 2017.Thematic report on the right to health in Guinea-Bissau. UN HR, Bissau, Guinea-Bissau.
[19] MINSAP. "Plano Nacional de Desenvolvimento Sanitário 1997-2001"

Sources: PNDS I (1997); PNDS II (2008); MINSAP (2016)

16. The available health workers are concentrated in urban areas, and vast, remote regions are left without a minimum health team. 51% of all physicians, and 40% of all nurses are based in the Bissau Autonomous Area (SAB), home to just 25% of the country's population. Populous regions such as Bafatá and Gabú show a systematic disadvantage in the deployment of all types of health personnel in favour of the Bissau and neighbouring Biombo areas. Medical specialists are all concentrated in the Bissau area – home to the country's level 3 hospital, and of a few private practices. When crossed with output indicators, it becomes apparent that workloads are extremely low across the country, with most health centers hosting around 20 birth deliveries per month, and regional hospitals carrying out fewer than 15 C-sections for the same period.

17. Scarcity of funds, political instability, and commercialization from within, emerge as the three key forces shaping human resources for health in Guinea Bissau. Noticeably little is currently allocated to health salaries by the state budget, the total wage bill for the health sector in 2015 was XOF216 million per month ($393,392) for the 2,173 health workers employed in the public sector. Remarkably, the State only pays for healthcare-related salaries, with all other expenses (medicines, goods and services, investments) being partially covered by external funds and by health facilities' own revenues. Incomplete data on external assistance combine with absent information on paid user fees to obscure true financing levels. 'Commercialization from within' means that most of the services and goods dispensed through the National Healthcare System are paid for out-of-pocket, through a multiplicity of statutory legal charges, and a myriad of illegal ones, some used to pay for health facilities expenses, but the majority pocketed by the health workers. As no financial system seems to be in place to truly recover the facilities' non-drugs costs, revenues from charges are likely to be entirely captured and managed by health workers acting as managers.[20]

18. This system of informal charges appears to be so institutionalized among health professionals and users alike, to be taken for granted as the official way of supplementing meagre and irregular salaries. The health workers appear to see the issue of charges as intimately related to their low and erratic remuneration, with many declaring feeling "abandoned" by the State, which barely and irregularly pays for salaries, and leaves health professionals fending for themselves for the facilities' recurrent expenses. As no effective inspection system is in place for the health sector, nature and extent of illegal charges seem to depend exclusively on the goodwill (and creativity) of the most senior officials in charge, on their ability to enforce those charges, and on consumers' ability to pay for the price.

19. The huge accountability deficit in the public health sector reflects the overall weak governance in the public sector. There is widespread impunity at all levels of the national health system and very few mechanisms to hold staff accountable for their actions.[21] Guinea-Bissau provides an extreme example of an ungoverned health workforce. Indeed, with little supervision, health workers have gradually become the de facto operators of the health system. They run the system in their favor, charging under the table fees and setting quality standards according to their will, which resulted in the creation of a private sector

[20] Russo, Giuliano, Enrico Pavignani, Catia Sá Guerreiro, and Clotilde Neves. 2017. 'Can We Halt Health Workforce Deterioration in Failed States? Insights from Guinea-Bissau on the Nature, Persistence and Evolution of Its HRH Crisis'. *Human Resources for Health* 15 (1): 12.

[21] UNIOGBIS, 2017.Thematic report on the right to health in Guinea-Bissau. UN HR, Bissau, Guinea-Bissau.

within the public health system.[22] The prospects of a stable public health sector job, with the potential to engage in additional profit-making activities within the system, resulted in the increased demand for health workers' training in the country and, consequently, a rapid expansion of private sector training (widely perceived as low quality).

20. Health personnel training increased dramatically between 2009 and 2015, but quality of training remains a concern. Cuban doctors run the public medical school, as part of a cooperation agreement between the governments of Cuba and Guinea-Bissau. However, medical students are taught by only a small number of Cuban doctors, often not per se specialists in the field they teach, such as pediatrics and obstetrics. It has been reported that teaching facilities lack basic infrastructure such as electricity, computers and textbooks, and a lack of specialty staff to supervise and conduct on-the-job training of junior medical staff. The training of nurses was expanded between 2009 and 2015, recurrent expenditures for nurses' courses have been supported exclusively by student fees - despite the relatively high fees (approximately USD500 over the two-year course), such courses were reported to be routinely oversubscribed. Additionally, there is no official accredited specialty training, nor policy on continuing clinical education.[23] Recently, two private medical schools started operating in Bissau, although programmes and facilities are still to receive accreditation from the MoPH, and one of the schools was shut down for irregularities in 2016-7. Factors like (a) applicants' education level, (b) poor competence of teachers, (c) teachers to student ratios,[24] and (d) sub-optimal clinical practice were identified as key constrains to quality training.

Health Sector Partnerships

21. The main international partners supporting the health sector include the European Union (EU), Global Fund, GAVI UNICEF, WHO, UNFPA, African Development Bank (AfDB), WFP, and a several non-governmental organizations (NGOs). The AfDB supported health sector funding for activities such as infrastructure for national hospital through 2015. GAVI has provided support to the Pentavalent and Yellow Fever vaccine programs since 2009, and added support to Pneumococcal vaccine in 2014, Rotavirus in 2015 and HPV and Meningitis in 2016. The Global Fund has been supporting the sector since 2005, and contributed US$10 million in 2016 for programs to fight HIV/AIDS, Malaria and Tuberculosis. The Global Fund is expected to continue supporting the health sector through 2020. Significant bilateral support is provided by the Swedish Cooperation (SIDA), the Portuguese Cooperation and the governments of Brazil and French.

22. Since 2013, the EU and the SIDA have been supporting the delivery of a basic package of maternal and child health (MCH) services. The EU funded the The Integrated Mother and Child Health Programme (PIMI I, PIMI-Gabu and PIMI II) and the EU-Saude.[25] The SIDA, together with other partners, funded the

[22] Russo et al., 2017. Can we halt health workforce deterioration in failed states? Insights from Guinea-Bissau on the nature, persistence and evolution of its HRH crisis. Human Resources for Health Journal.
[23] UNIOGBIS, 2017. Thematic report on the right to health in Guinea-Bissau. UN HR, Bissau, Guinea-Bissau.
[24] The National School of Public Health has 14 students per teacher (15 full time professors and 59 contracted part-time professors), and the School of Medicine has 13.8 students per teacher (32 medical doctors, all teaching in Bissau through an agreement with the Cuban government)
[25] Programa para a redução da Mortalidade Materno Infantil (PIMI).

H4+ in the country since 2013.[26] Through a combination of interventions, these projects covered all 11 regions of Guinea-Bissau at different times (see table 3). The interventions included in these projects were: (i) gratuity (user fees waiver) of selected MCH services (including diagnostic, transfers/referrals, and drugs); (ii) in-service training for health professionals in key MCH practices; (iii) payment of incentives to health facility administrators and health workers to reward good management practices and the delivery of selected medical interventions, respectively; (iii) support the community health strategy through the provision of equipment, training, supervision and payments of incentives to community health workers; and (iv) facility maintenance and rehabilitation, supply chain, and purchase of equipment.

23. These projects were implemented by international NGOs and the UNICEF. The French NGO *Entraide Médicale Internacionale* (EMI) implemented the payment of gratuity, payment of incentives to health facilities (management incentives), verification and monitoring, capacity building on management practices. The *Instituto Marques Valle Flor* (IMVF), a Portuguese NGO, provided in-service training (on Emergency Obstetric Neonatal Care, Integrated Management of Childhood Illnesses, and hematology), purchase and distribution of drugs, and the payment of incentives to health workers (clinical incentives). The community health component in all these projects was implemented by the UNICEF, which contracted NGOs (VIDA, AIFO, ADPP, AMI, Plan-International, and *Médicos da Comunidade*) to select, train, equip, supervise, and pay incentives to the community health agents (*Agentes de Saúde Comunitária, ASC*). The PIMI II, launched in October 2017, will cover all regions and keep the same implementation arrangements with EMI, IMVF, UNICEF and its collaborating NGOs.

Table 3: Key Maternal and Child Health Initiatives in Guinea-Bissau, 2013-2021

	PIMI	H4+	EU-Saúde	PIMI II
Coverage	Farim, Oio, Cacheu, Biombo, Gabu*	Bafata, Quinara, Tombali, Bijagos, Bolama, SAB	Bafata, Bolama, SAB, Bijagos, Quinara, Tombali	National (all 11 health regions)
Funding agency	European Union (90%) and partners (10% - UNICEF, Cooperação Portuguesa, NGOs)	European Union, Swedish International Development Agency	European Union (80%) and partners (20% - UNICEF, UNFPA, WHO, EMI)	European Union (80%) and partners (20% - UNICEF, Cooperação Portuguesa, NGOs)
Budget	8,877,904 €	6,900,000 USD	10,000,000 €	22,000,000 €
Timeline	July 2013 – July 2016	July 2013 – August 2015	February 2016 - May 2018	November 2017 – October 2021
Activities (Implementing agencies)	• Gratuity (EMI) • P4P (EMI & IMVF) • Community Health (UNICEF and NGOs)[27]	• Gratuity (EMI) • P4P (EMI, UNFPA) • Community Health (UNICEF and NGOs)[28]	• Gratuity (EMI) • Community Health (UNICEF and NGOs)[29]	• Gratuity (EMI) • P4P (EMI & IMVF)

[26] H4+, currently H6+, The partnership comprises six United Nations agencies: UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank, with the objective to provide support to countries to improve women's and children's health.
[27] VIDA, ADPP and AIFO.
[28] AIFO, AMI.
[29] AIDA, AMI, PLAN, VIDA, and Médicos da Comunidade.

	• Supply Chain/Drugs (IMVF & UNICEF) • In-service training (IMVF) • Rehabilitation of health centers/hospitals (IMVF)	• Supply Chain/Drugs (UNFPA e UNICEF) • In-service training (UNFPA, UN-Aids, WHO) • Rehabilitation of health centers/hospitals (UNFPA, UNICEF)	• Rehabilitation of health centers/hospitals (electricity and water – UNICEF)	• Community Health (UNICEF and NGOs)[30] • Drugs (IMVF & UNICEF) • In-service training (IMVF) • Rehabilitation of health centers/hospitals (IMVF)

** PIMI Gabu started implementation in 2014*

24. The private sector is small and largely unregulated. In 2016, only two of the 28 private health clinics visited by general health inspectorate (*Inspeção-Geral para Assuntos de Saúde*, IGAS) had adequate working conditions, yet they lacked the required documentation. No information is available on the condition of private health facilities outside Bissau. In 2014, there was an estimated 138 private pharmacies and medication sales facilities in the country. Of 111 inspected by IGAS, 5 were considered acceptable, and 70 were recommended to be closed. In 2016, a MINSAP decree established the principles to develop an accreditation process of health care providers.

Maternal and Child Health Challenges

25. The Guinean-Bissau health system faces structural challenges to provide essential services to its population. Low levels of public spending on health, high dependency on external financing, high household OOP payments, mal-distribution of the existing health workforce and acute shortages of key specialties of health personal, are the main challenges. Despite the obstacles, Guinea-Bissau, with the support of the international community, managed to make progress in extending coverage of basic MCH services, immunization coverage and reducing infant and child mortality. On the other side, the extremely high rate of maternal mortality, the low uptake of antenatal services and limited percentage of assisted deliveries, mean that some of the recent interventions have not yet achieve the full potential. Assessment conducted by the World Bank team identified both supply side and demand-side factors that influence the low uptake of services and the persistent low outcomes:

(a) **Lack of functional surgical capacity in the field**. Despite the observed presence of surgeons and surgical equipment, operation theatres may not be able to function and effectively provide services, because of lack of support personnel (anesthetists were reported to be particularly in scarce supply), or basic conditions, such as electricity, water or medical supplies;

(b) **Geographical barriers to accessing surgical services**. Either because of considerable geographical distance, and often difficult access, between *tabancas* and regional hospitals, or the lack of effective reference (transportation) between health centers and hospitals;

(c) **Financial barriers to services**. Surgical operations may be unaffordable because of the combination of formal (official user charges by health facilities) and informal charges (requested by health staff). There is anecdotal evidence on this (with reports that a C-section in SMH costing CFA75,000 in addition to all the surgical supplies), although the PIMI program, in principle, guarantees free access

[30] AIDA, AMI, PLAN, VIDA, AIFO, and Médicos da Comunidade.

through gratuity. Additionally, indirect costs with transportation and food are relatively high, particularly in rural areas;

(d) **Presence of alternative services and poor reputation of public services.** Women may prefer to follow traditional ways of assisted birth, and only resort to public services in case of complications during delivery. Perceived poor quality of services may also discourage seeking care at health centers and hospitals;

(e) **Lack of accountability**: There is also a large accountability deficit in the Guinean-Bissau health system. The MINSAP has recognized the "widespread impunity at all levels" of the national health system, even where managers try to enforce technical and financial standards, they face a lack of support and inevitably become frustrated and demotivated. A recent UN-report concludes that important deficits in accountability are among the key factors stymying progress in the health care system.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To improve utilization of essential maternal and child health services in Guinea-Bissau.

Key Results

PDO-level indicators:

(a) Pregnant women receiving at least four antenatal care visits;
(b) Institutional deliveries;
(c) Use of modern contraceptive methods among women of reproductive age;
(d) Number of children (0-11 months) fully vaccinated.

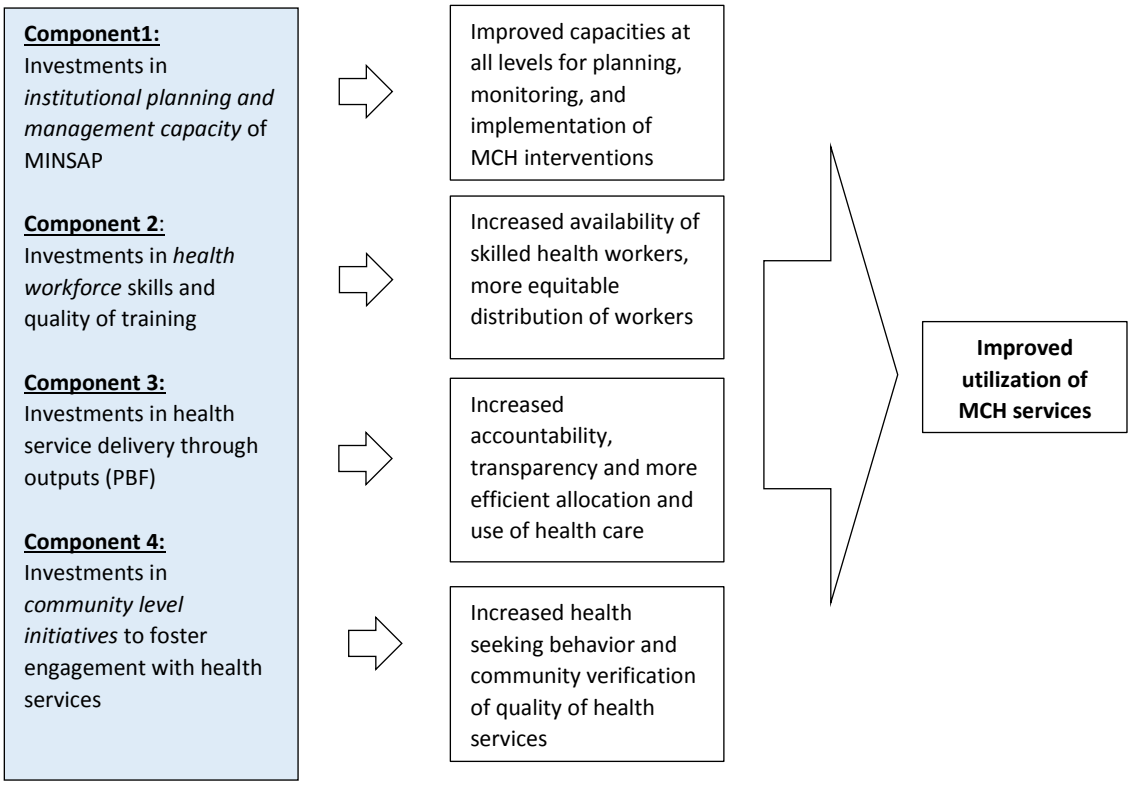
D. Project Description

26. The Project comprises four components that together will address the key challenges to improve maternal and child health outcomes in the country. The first two aiming at strengthening national MINSAP capacity to perform key health systems functions and to improve availability, quality and distribution of the health personnel. Components III and IV aim at improving the access to and quality of maternal and child health services and increase accountability within the health care system through PBF and community health interventions. The four components are as follows: (i) Institutional strengthening of the Ministry of Public Health (MINSAP); (ii) Health workforce development; (iii) Performance-Based Financing (PBF), to deliver a package of essential maternal and child health services; and; and (iv) Community health and social mobilization.

27. These components seek to combine supply and demand sides interventions to address the challenges laid out in the sectoral context. On the supply-side, the Project will support the rehabilitation of health facilities, improving the skills of existing and future health personnel, increasing accountability within the health care system and decrease the widespread practice of informal charges through the introduction of a performance-based financing (PBF) scheme and strengthening governance at all levels of the MINSAP. The fourth component will support strategies that address demand-side challenges, including supporting the existing community health agents program, and social mobilization to stimulate

citizen engagement to bring about behavioral change. The combined action of all project components will improve utilization of maternal and child services and, ultimately, improve health outcomes, as described in the project theory of change (Figure 1).

Figure 1: Theory of Change between interventions and project development outcome



28. Component 1: Institutional Strengthening of the Ministry of Public Health (US$2.9 million). This component will support institutional strengthening at the national, regional, and local levels to increase transparency and accountability across the health system. In addition to support project implementation, this component will also support analytical work and policy dialogue to facilitate the implementation of key institutional reforms. This component includes two main subcomponents.

29. *Subcomponent 1.1: Institutional reform of the MINSAP (US$0.8 million)*: This subcomponent will focus on strengthening the MINSAP's management capacity at all levels. It will support technical assistance to review the current organizational structure of the MINSAP and to provide recommendations for reform. The review of the organizational structure entails a thorough revision of the terms of reference, roles, and responsibilities of units and roles across all levels of the ministry. The goal of the MINSAP institutional reform is to establish roles and responsibilities within the ministry, to strengthen accountability between actors at the national, regional and local levels, and to improve the distribution and management of human resources management (HRM) across all levels of the public health system. Activities under this subcomponent include: (i) A comprehensive assessment of the MINSAP institutional organization, revising and developing terms of reference for each unit across all levels of the public health system; (ii) Support the implementation an institutional reform of the MINSAP based on the findings and

recommendations of the institutional assessment; (iii) Review and strengthen HRM practices at all levels of the public health system; (iv) Support health workforce regulatory reforms needed to improve availability of skilled health professionals, particularly in rural; (v) Support MINSAP staff development by building capacity in areas such as HRM, budget planning and execution, public financial management (PFM), and monitoring and evaluation (M&E).

30. ***Subcomponent 1.2: Project Management and Monitoring & Evaluation (US$2.1 million).*** This sub-component will provide support to the operation of the project implementation unit (PIU), which will be the same PIU of the REDISSE Project. The PIU will support the day-to-day project management, fiduciary tasks, M&E, and other logistical support to the implementation of Project activities. The sub-component will also support the impact evaluation of the PBF pilot, which will inform the scale up strategy of the PBF program, and fund the implementation of a Service Delivery Indicators (SDI) survey during the final year of the project (one wave of the SDI is currently being implemented by the National Statistical Office (INE) in collaboration with the MINSAP and the World Bank).

31. Component 2: Health workforce development (US$3.2 million). This component aims to address key health workforce shortcomings that limit the country capacity to improve service delivery to its population. The health workforce challenges include low quality of training, insufficient skills and competencies from clinical cadres, acute shortages of key clinical cadres (such as pediatricians, obstetricians, and gynecologists), absence of quality assurance mechanisms to guarantee minimum standards of training and practice, and the uneven distribution of health workers across the country (concentrated in the capital Bissau). Given that sub-component 1.1 will support the improvement of HRM practices and procedures, Component 2 will focus on health workforce challenges through strategic investments to improve the country's training capacity, support decentralized training, improve competencies of existing health workers, and implementing mechanisms to enforce minimum standards of training and practice. This component has two sub-components, as follows:

32. ***Sub-component 2.1: In-service training (US$1.4 million).*** This sub-component will target health workers currently employed in the public health system with the goal of upgrading specific competencies related to MCH service delivery. These competencies include but are not limited to emergency obstetric and neonatal care skills, obstetric surgical skills, anesthesia, echography, and provision of routine care for mothers, neonates and infants. Activities under this subcomponent includes the development and implementation of in-service training modules across all sanitary regions. This sub-component will also support, in collaboration with UNICEF and the European Union (EU), the development of continuing education plans and materials for health personnel and community health agents.

33. ***Sub-component 2.2: Pre-service training (US$1.8 million).*** This sub-component will support the National School of Public Health and the National School of Medicine to improve the quality of nursing, midwifery and medical education. This sub-component will support activities such as faculty development, curriculum reform (to implement competency-based training), the development of training capacity to produce basic medical specialties in the country, introduction of mechanisms to assess and control quality at entry and at graduation, development of standards to measure quality of training (in public and private schools), and purchase and installation of didactic equipment for the National School of Public Health and the National School of Medicine, including the creation of the National Public Health Library. In line with the CPF 2017-22, the subcomponent will support improvements in the physical and training capacity in the three regional campuses of the National School of Public Health with the goal of

increasing the availability of skilled professionals, nurses and midwives, at the local level.

34. Component 3: Performance-based financing, to deliver a package of essential maternal and child health services (US$10.1 million). This component will focus on strengthening PHC service delivery in the entire country. Such a model would involve coordination and care provision by integrated frontline PHC teams including nurses, midwives, physicians within health centers, regional hospitals and the national hospital, linked to community and outreach services provided by community health agents. This component will combine investments to improve health facilities conditions and incentives to boost health workers' performance, accountability and transparency within the health service delivery chain. Two sub-components are envisioned under this component:

35. ***Sub-component 3.1: Health facility grants (US$2.9 million).*** The sub-component will provide grants to health facilities to improve health service delivery capacity. These grants could be used for small repairs inside selected health facilities (painting, electricity and equipment installation, etc.), to improve surgical capacity, and to purchase essential equipment and supplies. At the beginning of the PBF scheme health facilities will submit grant proposals which will be assessed and approved by the PIU within pre-defined parameters for investments. These proposals would include a detailed description of how the facilities would manage and use the PBF funds, including how communities will participate in the decision of use the grant and PBF funds. These grants would ensure that all facilities entering the PBF scheme would have adequate operating conditions.

36. Sub-component 3.2: Performance-based payment (PBF) (US$7.2 million). This subcomponent will provide performance bonuses to: (i) health facilities, conditional on list of quantity and quality indicators linked to the delivery of a package of MCH services; and (ii) the 11 Regional Health Directorates (DRS) for verifying the quantity and quality of services provided at both community and health facility levels. Health facilities contracted health facilities will use PBF payments to provide financial incentives to health personnel to increase the quality and the quantity of health services provided at the facility and through outreach strategies, and to fund facility operating costs. The ultimate objective of the PBF program is to change health personnel behavior to improve and accountability in the service delivery. The introduction of PBF in Guinea-Bissau would rest on the assumption that, through its sub-components, the intervention would have a direct effect on the supply-side barriers hampering the provision of services that can reduce maternal and infant mortality.

37. Facility payments will be made quarterly based on both a set of incentivized indicators emphasizing reproductive, maternal and child health, and nutrition interventions. A list of output indicators will be defined for primary and tertiary care. In addition to the payments based on the quantity of services provided, a quality bonus will be provided and which will increase of up to 30% of the total payment based on health service quantity. This percentage depended on the health facility quality score. A quality checklist will be designed for each level of the service package and will focus on the availability of medicines and supplies, good maintenance of facilities, listing user charges, privacy, the condition of the waiting area and consultation room, proper documentation of health services, and other aspects of service delivery. A remoteness bonus will be included to health facilities located in hard-to-reach areas of the country. This bonus aims to provide further incentives to health personnel to practice in these areas and to provide financial conditions to these health facilities to implement outreach activities. The sub-component will also support PBF implementation by contracting an independent verification agency and proving technical assistance to support the implementation of the PBF program.

38. Component 4: Community Health and Social Mobilization (US$8.8 million). This component will support the continuation of the community health strategy in the country and will engage communities to promote health-seeking behavior, dissemination of information, and monitoring of service providers. The objectives are to improve the demand of key reproductive, maternal and child health services, and to sensitize the population on health promoting and disease preventing behaviors through community-based interventions. Activities included in this component will range from recruitment, training, and payment of incentives to community health workers; outreach activities to inform, sensitize and raise awareness about harmful cultural practices such as female genital mutilation; facilitate monitoring of health services; and involving communities on planning and execution of improvements of health centers. The component will include the following sub-components.

39. ***Sub-component 4.1: Community Health Worker Program (US$7.6 million).*** This sub-component will support the implementation of the community health strategy in the country. The project will provide financial incentives to CHWs based the delivery of a package of essential community and preventive services defined by the MINSAP. Payments to CHWs will be made directly through mobile money transfers (already tested for that purpose). Performance payments will be linked to a pre-defined list of 16 activities listed in the National Community Health Plan 2016-2020, these include household visits, health promotion and prevention, referral to health centers, and the distribution of basic health care inputs. The sub-component will finance incentive payments to community health agents (4,287 CHWs in the country with a monthly payment of approximately CFA 15,000), and it will support UNICEF and its associated NGOs in the provision of training and supervision of the CHWs (including verification of service delivery by CHWs).

40. ***Subcomponent 4.2: Social Mobilization and Support (US$1.2 million).*** Activities under this subcomponent includes: (i) support community mobilization and organization for monitoring of health service delivery; (ii) promotion of social and behavior change communication; and (iii) support the expansion and maintenance of maternal waiting homes. The sub-component will support the creation and functioning of women's groups to engage communities in the monitoring of service delivery at facility level and incentivize social accountability. This sub-component will support the development and implementation of community scorecards to assess health facilities' infrastructure and equipment (including accessibility, staffing, infrastructure, water, electricity, and availability of essential drugs), and quality of services provided (including information exchange, client-provider interaction, and illegal charges). Scorecards will be piloted in PBF pilot regions before scaling-up nationally. Other activities under this component include support the development and delivery behavior change messages on intersecting topics (reproductive health, nutrition practices, hygiene, safe delivery, and harmful traditional practices such as genital mutilation) that influence MCH outcomes, and maintenance of maternal waiting homes (MWHs, *Casa das Mães*).

41. Component 5: Contingent Emergency Response Component (CERC) (US$0). This component would allow funds to be quickly reallocated to emergency activities in the event of a natural or man-made disaster or crisis that has caused, or is likely to imminently cause, a major adverse economic and/or social impact.

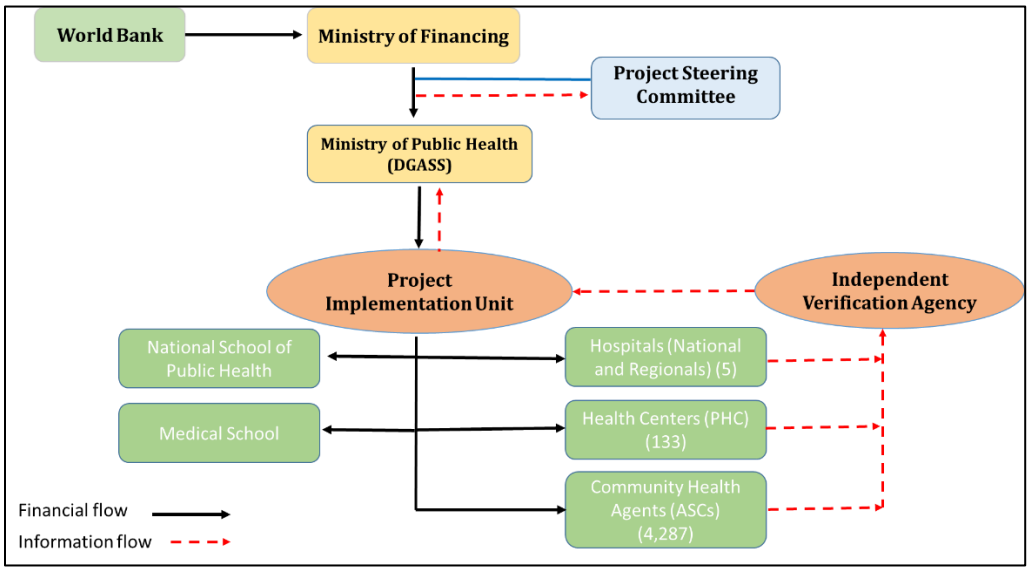
E. Implementation

Institutional and Implementation Arrangements

42. The General Directorate of Administration of the Health System (DGASS) of the Ministry of Public Health (MINSAP) will be the government unit responsible for the implementation of the proposed project. The Project Implementation Unite (PIU) will be the same PIU that was established for the coordination of the REDISSE II Project, which became effective in September 2017, and works under the coordination of *Célula de Gestao do Plano Nacional de Desenvolvimento Sanitário* (CG-PNDS). The PIU will report directly to the Secretary-General of the MINSAP and will be responsible for the day-to-day management of the project and will: (i) to coordinate the project activities; (ii) ensure the financial management of the project activities in all components; (iii) act as "payer" for the incentives under the PBF under component 3; and (iv) prepare consolidated annual work plans, budgets, monitoring and evaluation (M&E), and the implementation report of the project to be submitted to the steering committee and the World Bank.

43. A Project Steering Committee (PSC) will be established to provide strategic direction and monitor the overall progress of the project. Membership of the PSC will consist of representatives from MINSAP, Ministry of Finance, Ministry of Education, The Ministry of Women, Family and Social Cohesion (MWFSC), representatives of local, regional and global partners (European Union, UNICEF, UNFPA, WHO, USAID, Global Fund and others), and civil society representatives. The PSC will approve annual work plans and annual reports. It will be chaired by a ranking official of the Ministry of Public Health (possibly the General Secretary of the MINSAP).

Figure 6: Project Implementation arrangements



F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

The project has national coverage, and focuses on community-based health services delivery and related strengthening of national capacities. The project will not finance the construction of health centers or other physical structures (e.g., additions or expansion of existing structures).

G. Environmental and Social Safeguards Specialists on the Team

Gernot Brodnig, Social Safeguards Specialist
Medou Lo, Environmental Safeguards Specialist
Melissa C. Landesz, Environmental Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The project triggers Safeguards Policy OP/BP 4.01 (Environmental Assessment) and is classified as category B project given the likely increase in biomedical waste due to improved coverage and quality of maternal and child health services across the country. The Medical Waste Management Plan, prepared under the Regional Disease Surveillance Systems Enhancement (REDISSE - P154807) will be assessed, updated, consulted upon and disclosed before appraisal both in country and at the Bank web site prior to appraisal.
Natural Habitats OP/BP 4.04	No	The project does not affect or involve natural habitats.
Forests OP/BP 4.36	No	The project does not involve forests.
Pest Management OP 4.09	No	The project does not involve pest management.
Physical Cultural Resources OP/BP 4.11	No	The project does not affect or involve physical natural resources.
Indigenous Peoples OP/BP 4.10	No	The Project does not affect indigenous peoples
Involuntary Resettlement OP/BP 4.12	No	The project does not involve land acquisition leading to involuntary resettlement or restrictions of access to resources.
Safety of Dams OP/BP 4.37	No	There are no dam-related activities in the project.

Projects on International Waterways OP/BP 7.50	No	There are no activities related to international waters in the project.
Projects in Disputed Areas OP/BP 7.60	No	The Project is not located in a disputed area as defined by the policy.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
The project is classified as Category B - Partial Assessment for Environmental Assessment (EA) purposes. It triggers OP 4.01 Environmental Assessment because of the anticipated increase in biomedical waste due to improved coverage and quality of maternal and child health services across the country.
Sub-component 3.1 will finance health facility grants that may be used for small repairs inside selected health facilities (painting, electricity and equipment installation, etc.), to improve surgical capacity, and to purchase essential equipment and supplies. Such activities are consistent with a Category C classification and will be implemented according to the relevant national laws and with appropriate mitigation measures as needed. Beyond these small interior repairs and improvements, the project will not finance any works.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
While the increase of biomedical waste is an indirect impact of the project activities, it is important to ensure that this Health Risk Waste will be properly handled, collected, transported and eliminated to avoid the spread of infectious diseases.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
N/A

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
A Medical Waste Management Plan (MWMP) for Guinea-Bissau was prepared under the Regional Disease Surveillance Systems Enhancement (REDISSE - P154807) and disclosed in country on January 13, 2017 and at the World Bank on January 12, 2017. The MWMP provides: a) measures for addressing shortcomings identified in the waste management system including guidelines for improving the legal framework; b) institutional arrangements for proper HCW management in the country; c) an implementation action plan with an associated budget; d) guidance on training for health care practitioners; e) monitoring and evaluation plan; and f) awareness raising strategies for the public.
The MWCP was reviewed and deemed appropriate as the safeguards instrument for this project given the indirect impacts discussed above. It was updated to reflect this dual coverage and disclosed in-country on February 21, 2018 and at the Bank on February 23, 2018.
Concerning the Health Facility Grants and the small interior repairs and improvements they may finance, the Borrower will review the proposals carefully prior to approval to (1) ensure that they are aligned with these guidelines and (2) will be implemented according to the relevant national laws and appropriate mitigation measures if needed.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.

The key stakeholders are women and children who relies on public primary and secondary care for their health care needs, particularly pregnant women and children under 5 (and their representatives) as well as the Ministry of Public Health and the health workforce involved in MCH service delivery. Consultations on and disclosure of the MWMP occurred during preparation of REDISSE and re-disclosure of the document for the current project occurred in-country on February 21, 2018 and at the Bank on February 23, 2018.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
31-Jan-2018	23-Feb-2018	

"In country" Disclosure

Guinea-Bissau

21-Feb-2018

Comments

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?

Yes

If yes, then did the Regional Environment Unit or Practice Manager (PM) review and approve the EA report?

Yes

Are the cost and the accountabilities for the EMP incorporated in the credit/loan?

Yes

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?
Yes

Have costs related to safeguard policy measures been included in the project cost?
Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?
Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?
Yes

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APPROVAL

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