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Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 14-Sep-2017 | Report No: PIDISDSC22177

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Guinea-Bissau	P163954		Strengthening Maternal and Child Health Service Delivery in Guinea-Bissau (P163954)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	Feb 02, 2018	Apr 19, 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 coverage and quality of essential maternal and child health services in Guinea-Bissau.

Financing (in USD Million)

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

Environmental Assessment Category	Concept Review Decision
B-Partial Assessment	Track II-The review did authorize the preparation to continue

Note to Task Teams: End of system generated content, document is editable from here.

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 per capita of US$590 (2015), around 70% of the population lives in moderate poverty (PPP US$2 per day) and about 33% in extreme poverty (PPP $1 per day). 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). Guinea-Bissau ranks 178th out of 188 countries of the 2016 Human Development Report. The population of Guinea-Bissau is estimated at 1.88 million (2016) of which 51.5% lives in urban areas and 21% lives in the capital Bissau. The majority of the population, particularly the rural poor, has limited access to basic goods and services that directly influence the wellbeing of households. As a result, poverty rates in 2010 were higher in rural Guinea-Bissau (76%) than in the capital Bissau (51%).

2. The economy is dominated by agriculture, accounting for over 40% of 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. The country has experienced fairly strong economic growth in the recent years with an average gross domestic product (GDP) growth of 4.1% between 2014 and 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.

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. Indeed, 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 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 has achieved some progress in health in the recent years, but nevertheless some critical challenges remain. 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).[1] The country's health system faces persistent challenges related to inadequate supply of health workers, low public spending, poor infrastructure and weak governance.

5. 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, one of the highest in the world.[2] 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. Progress has been made to reduce child mortality, but both infant mortality rate (IMR) and under-five mortality rate (U5MR) remain among the highest rates in the world, 60 and 89 per 1,000 live births, respectively.[3]

6. The utilization of obstetric services by expecting mothers in Guinea-Bissau has been persistently low for several years. Only 45% of the deliveries take place within health facilities.[5] A recent assessment by a European Union funded project showed that out of every 100 women having at least one antenatal care visit only 37% delivered their babies in a health facility and only 38% of women had the standard four antenatal consultations.[4] Key contributing factors include: (i) on the supply side, an acute shortage shortages of critical cadres and specialties (such as midwives, surgeons, obstetrician, and gynecologists), weak infrastructure, low availability of surgical services, and medicines. Moreover, obstetric care in most regions is provided by general nurses, most of whom are males; (ii) on the demand side, a set of issues have been pointed out as reasons to not utilize maternal health services, such as high costs (including costs of medicines), under the table payments, the perception of low quality of services, and socio-cultural factors.

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 uses any contraceptive method, and the adolescent pregnancy rate is estimated at 28%.

[1] World Bank, 2016. Guinea-Bissau Health Sector Diagnostic. World Bank, Washington, DC.
[2] UNICEF, 2015. Multi Indicators Cluster Survey.
[3] World Development Indicators, 2016.
[4] European Union, 2016. Assessment of the *Programa Integrado para a Redução da Mortalidade Materno-Infantil* (PIMI). Bissau, Guinea-Bissau.

8. Guinea-Bissau has a very high burden of malnutrition, which directly correlates with maternal and child mortality. According to 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.[5] 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 under five years is 27.6%.[6] Moreover, Guinea-Bissau has a higher burden of deaths and DALYs due to nutritional deficiencies compared to structural and regional peers. Many international reviews have pointed out 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 better-nourished child.[7]

Health Financing

9. Health care spending per capita in Guinea-Bissau is the lowest among countries in the sub-region. In 2013, the per capita spending on health was US$37, 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, since it accounts for only 20% of total health expenditures (THE), much lower than the average among for West African countries (32%). Additionally, government spending is mostly to pay staff salaries, while donors finance nearly 90% of the recurrent costs of the sector, including medicines and other critical health inputs. While there have been efforts to increase coordination between the development partners in the health sector (World Bank, the Global Fund, European Union, the Global Alliance for Vaccines and Immunization (GAVI), WHO, UNICEF, UNDP and others), the presence of multiple actors has created duplication of service delivery and vertical programs (such as for Malaria, HIV, and Tuberculosis). Since 2016, the World Bank, UNDP, UNICEF and the European Union are leading the efforts to establish a health sector coordination mechanism to reduce the fragmentation in the sector.

10. Despite the limited public health budget, the Ministry of Public Health (MINSAP) has not been able to execute its budget entirely. The MINSAP budget execution was approximately 50% in 2014 and decreased to 42% in 2015. The only category with high execution rates was personnel costs. It does not necessarily reflect any prioritization of health sector staffing. Instead, a bare change of budget on personnel may just stem from a lack of strategic planning and the high execution rates have just benefited from the established payment mechanism. In other areas where such mechanisms are lacking, the low execution rates indicate the limited government capacity to strategically plan and implement health policy actions in the medium and long terms.

11. Out-of-pocket (OOP) payments represent the largest source of financing, 49.5% of THE. On average, households spend 15% of their non-food expenditures on healthcare. A recent World Bank report shows that OOP payments are not associated with improved access to health services.[8] For example, the number of deliveries assisted by a qualified health

[5] World Food Programe, 2013. Synthesis of Rapid Food Security Assessment. Bissau, Guinea-Bissau.
[6] UNICEF, 2015. Multi Indicators Cluster Survey.
[7] 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).
[8] World Bank, 2016. Guinea-Bissau Health Sector Diagnostic. World Bank, Washington, DC.

professional is low in the regions with higher OOP payments (Gabú and Bafatá). Similarly, the percentage of pregnant women with four or more antenatal visits is higher in the regions with relatively low OOP payments (Quinara and Oio). Additionally, higher OOP is not associated with improved health outcomes: the regions of Oio, Quinara, and Biombo have the lowest neonatal and child mortality rates and households living in these regions make relatively lower OOP payments for health. On the other hand, households in Gabú and Bafatá spend more on health care through OOP payments and face higher-than-average rates of neonatal and child mortality.

12. Approximately 12% of the households in the country incurred catastrophic health expenditures.[9] Accordingly to the World Bank, OOP expenditures increase the absolute and extreme poverty headcount ratio by 1.4 and 1.1 percentage points.[10] This means that every year 1.1% of the population (~15,000 people) is pushed into extreme poverty due to health care payments. Furthermore, the estimate of the poverty gap (the shortfall of the total population under the extreme poverty line) rises hereby by 6.4 percent. The normalized poverty gap also increases from 11.06 to 11.77% and the mean poverty rate increases by 2.9%. This suggests that the rise in the poverty gap resulted in both more households being brought into poverty and a deepening of the poverty of the already poor due health care payments.

Health Service Delivery

13. Health service delivery in Guinea-Bissau is structured around 11 districts, hierarchized among local, regional and central levels. The local level comprises 114 sanitary areas, which are the primary locus for implementation of health sector activities through the health centers. The regional level provides technical support and coordinates the sanitary areas. This level contains an administrative structure, regional health directorate (DRS, *Direcao Regional de Saude*), and technical units such as the regional hospitals and the drugs warehouses. The central level is responsible for setting health policies, strategies and regulations. At this level are the National Hospital (*Hospital Nacional Simao Mendes*), specialized hospitals (for specific diseases or conditions, such as tuberculosis, and mental health) and satellite health centers.[11] Primary health care facilities are classified into three types (A, B, and C), distinguished by their capacity to deliver more or less complex health interventions. Health centers type A, for example, can perform surgeries. These primary health care centers are responsible for the implementation of the *Pacote Minimo de Atividades* (minimum benefits package), which is composed of five groups of activities (curative activities, preventive activities, communication and health promotion).[12]

14. There is a wide variation in the distribution of health facilities across the country. Hospital bed density, for example, varies from 0.56 to 2.29 and shows no association with U5MR. Bissau concentrates around 46% of the total of hospital beds, followed by Cacheu, which has 11% of the total number of hospitals beds in the country. Similarly, the concentration of any health facility (per 100,000 population) varies from 4.35 to 38.8, although the highest value (Bolama) is an outlier due to a small population. As for hospital beds, there is no association between facilities density by population and mortality. However, there is a strong association between facilities concentration by area and U5MR. It is interesting that Oio has a low U5MR despite a fairly low facilities density by area; this likely results from the fact that

[9] Defined as households that allocate more than 40% of the households' non-food expenditures to health care.
[10] World Bank, 2016. Guinea-Bissau Health Sector Diagnostic. World Bank, Washington, DC.
[11] Republica da Guinea-Bissau, 2008. Plano Nacional de Desenvolvimento Sanitario. Ministerio da Saude Publica. Bissau, Guinea-Bissau.
[12] There are 5 type A centers, 16 type B centers and 87 type C centers.

much of Oio's population resides in the city of Farim, which has a significant concentration of clinics and therefore the distance barrier is small.

Access to health care

15. Access to health care services is significantly associated with economic status in Guinea-Bissau. According to the ILAP II survey, 69.4% of people sought health care if they fell ill during four weeks before the survey. At the household level, health seeking behavior was clearly associated with household economic status: 75% among the richest quintile received any form of health care, while 63% of the lowest quintile received care. After controlling for region, type of disease and household demographic characters, richer households are still significantly more likely to visit a health facility than their poorer counterparts. A similar pattern is observed across regions; namely, that poverty level is indicative of residents' likelihood to access healthcare. For example, among those living in the poorest region (based on the moderate poverty line, $2 per person PPP per day), Quinara, 60% accessed health care when ill, the lowest percentage in the country. On the other side, approximately 80% of those who fell ill in Oio accessed health care services, a higher proportion than those regions with less moderate poverty.

16. Health care costs were reported as the main reason for not seeking health care when needed. On average, 44% of the 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%). 10.5% of the interviewees reported that providers being located too far away from respondents' home was the second main reason for not seeking care. For example, there is evidence that 52% of Bissau-Guineans have to travel for over an hour to reach their most proximate health care facility, which is usually a 'type C' facility providing only the most basic health care interventions.[13] Across regions, there was no evidence that relatively better-off regions have more affordable healthcare. In Cacheu (58%), Bissau (51%) and Gabú (51%), the percentage of those reporting health care costs as the main barrier to seeking care was higher than the national average. Regarding health care providers' location convenience, Quinara (26%), Oio (21%), and Bolama (20%) reported the highest rate of complaints.

17. Perceived quality of health care services is generally low. Among those who ever visited any health facilities, 42% reported at least one problem with it. Those at the bottom of the income distribution (20% poorest) had, on average, the highest satisfaction rate, which is likely to be associated with lack of knowledge rather than the actual quality of services. Across regions, the highest percentage of individuals reporting problems with health care delivery was in Cacheu (55.5%), Quinara (50.9%) and Tombali (48.3%). The lack of supervision and solid educational attainment amongst health care workers limits the provision of quality care.

Health Workforce

18. The country's health system faces persistent challenges related to the inadequate supply of health workers. There are both absolute and relative shortages of health workers. Firstly, there are relatively low numbers of health workers to fulfill population needs, namely 1.23 health workers per 1,000 population in the country in 2016. The density of nurses

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

to 1,000 population is 0.61, 0.12 for doctors and 0.08 for midwives. Secondly, the available health workers are concentrated in urban areas, and vast, remote regions are left without a minimum health team. Finally, there are imbalances in the skill mix with shortages of critical cadres and specialties – such as midwives, surgeons, obstetrician, and gynecologists. Additionally, health workers' salaries are low compared to regional standards and the government has not been able to pay workers regularly due to lack of funds. These non-payments, combined with the inadequacy of medicines and equipment, adversely affect staff motivation and resulted in deterioration of the quality of public service and incentivize under the table payments, which tend to affect the poor disproportionately.

19. Across the country, the distribution of the health workforce is highly uneven. More than half of Guinea- Bissau's health workforce practices in the capital Bissau. Considering only the number of doctors, nurses, and midwives, the regions of Bolama, Bissau, and Biombo have the highest health workforce density, 1.99, 1.48 and 1.24 respectively. On the other side, the regions with the highest mortality burden, Gabú, and Bafatá, face critical health worker shortages with population densities equal to 0.42 and 0.50 per 1,000 people, respectively.

20. The processes of recruitment, training and compensate health workers are irregular and inefficient. The recruitment and hiring processes run ad-hoc, newly graduated candidates coming from different national health national training schools or from abroad are automatically contracted within the MINSAP. Therefore, the MINSAP absorbs all new graduates from medical, nursing and other mid-level cadres training programs, public and private. Although it still may not fulfill the country's need given the shortage of health professionals, particularly in rural areas, the current hiring policy is not based on any rigorous assessment of the needs on the ground neither look at the existing fiscal space to balance the demand and supply sides of the 'hiring market'.

21. The weak governance in the public sector is reflected in the public health sector in the form of a large accountability deficit. There is widespread impunity at all levels of the national health system and very few mechanisms to hold staff accountable for their actions.[14] Guinea-Bissau provides an extreme example of 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 set quality standards according to their will, which resulted in the creation of a private sector within the public health system.[15] 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 viewed as of low quality).

22. Quality of health workers' training is an imperative 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. Additionally,

[14] UNIOGBIS, 2017.Thematic report on the right to health in Guinea-Bissau. UN HR, Bissau, Guinea-Bissau.
[15] 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.

there is no official accredited specialty training, nor policy on continuing clinical education.[16] Factors like (a) applicants' education level; (b) poor competence of teachers; (c) high teachers to students ratios, and; (d) sub-optimal practice sites, were identified as key constrains to quality training.

C. Proposed Development Objective(s)

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

Key Results (From PCN)

The following outcome indicators will be used to measure the achievement of the project development objectives (PDOs):

PDO-level indicator (proposed)
- Proportion of pregnant women receiving at least four antenatal care visits (rate)
- Proportion of birth deliveries attended by skilled health personnel (rate)
- Proportion of boys and girls 0 to 5 years of age fully immunized (rate, disaggregated)
- Pregnant women and children receiving basic nutrition services (number)

Intermediate-level indicators (proposed)
- Health workers who received training (number)
- Satisfaction rate of beneficiaries on health care delivered by Health Centers (rate)
- Post-natal consultation visits (number)
- Visits by under-5 children to health facilities (number)
- Children under the age of 5 treated for severe and acute malnutrition (number)

D. Concept Description

The proposed project aims to improve access to essential maternal and child health services by strengthening core health systems functions in the country. The proposed project builds on the technical assistance by the World Bank, the National Health Sector Development Plan, and the CPF FY18-21. The proposed project will target on the health service delivery bottlenecks identified in these documents through four complementary components: 1) Strengthening and expanding the community-based primary healthcare service delivery model; 2) Health workforce development; 3) Support community participation to improve accountability and quality of health service delivery; and 4) Strengthening the Ministry of Public Health planning and management capacity. The proposed project aims to adopt a flexible approach that combines interventions to address immediate needs (reduce maternal and child deaths) and interventions to strengthen the health system in the medium- and long-terms (improve governance, management capacity, health workforce quality and the incentive environment within which health workers operate).

Component 1: Community-based health service delivery. This component will focus on strengthening and expanding community-based primary health care service delivery model in the entire country. Such a model will involve

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

coordination and care provision by integrated frontline primary healthcare teams composed primarily of paid community health workers, auxiliary nurses, trained midwives, with the support of graduate nurses and physicians. This service delivery model can be implemented in the short-term, at lower cost, through public and private initiatives (social enterprises, for example). [17] Three subcomponents are envisioned under this component: i) Scale up community-based primary health care service delivery model to the entire country; ii) Strengthen community level outreach and basic service delivery. This includes support the government to institutionalize training and contracting of community health workers to generate demand for services and deliver basic nutrition, reproductive, maternal and child health services; iii) A results-based financing scheme linked to the delivery of essential health and nutrition services to pregnant women, mothers and children. This will reward frontline health workers and facilities (public health centers and district hospitals) against the provision of pre-identified services (e.g., primary health care and preventive services for pregnant women, deliveries and post-partum care, immunization services, care for children under the age of 5, family planning, etc.).

Component 2: Health workforce development. This component aims to address key health workforce shortcomings that hinder the country's health system ability to provide quality and affordable health care to its population, particularly the poor. Four activities are planned under this component: i) provide in-service training (at district level) to existing health workers and upgrading their competencies related to maternal and child health service delivery and promotion; ii) provide training and capacity building for *Fanatecas* (women conducting FGMs), including employing them within the health sector (as midwives and/or community health workers); iii) improve the quality of health professionals' training by providing strategic support to the medical, nursing and midwifery public schools (support would include faculty development, purchase of equipment and learning materials and development of quality assurance mechanisms to improve the quality of health professionals' training); vi) Strengthen health workforce policies (this includes defining clear career pathways for different health workers, revision of the remuneration policy to implement performance-based pay and introduce non-monetary incentives).

Component 3: Community participation. The objective of this component is to support activities that can leverage citizen engagement to increase accountability, to improve the demand of key nutrition, reproductive, maternal and child health services and to change behavior (to reduce harmful cultural practices such as female genital mutilation). This will include the following sub-components: i) support community engagement to improve quality and accountability, which includes putting in place mechanisms to allow community participation (at the district level) in the design and implementation of health interventions; ii) implement a national awareness campaign and legal literacy training by developing media materials and workshops, incentivizing community participation and other activities to reduce FGM; iii) Support community mobilization for improving nutrition, focusing on child growth promotion, infant and young child feeding practices, community management of acute malnutrition, and food diversification; iv) support activities to influence social and behavior change, including promotion of key family and community practices that promote health and nutrition needs of pregnant women, children and adolescents, and influence health care seeking behaviors. This component will align its efforts with the conditional cash transfer being developed by the Social Protection and Labor team.

Component 4: Strengthen the Ministry of Public Health planning and management capacity. This component aims to

[17] Lim and Chia (2016). Social entrepreneurship: improving global health. Journal of the American Medical Association, Vol. 13(22).

support strengthening of core Ministry of Public Health functions across the national health system to increase transparency and accountability at the regional and national levels. This component includes three activities: i) Conduct a comprehensive institutional assessment of the Ministry of Public Health, by revising each unit's (and individual staff) role and responsibilities to propose recommendations to improve governance capacity; ii) Support institutional reform of the Ministry of Public Health (at national and regional levels) based on the findings and recommendations of the institutional assessment; iii) Support staff development (building capacity in areas such as human resources management, budget planning and execution, and monitoring and evaluation)

Component 5: Project Management and Monitoring and Evaluation. This subcomponent will support the set-up and functioning of the project implementation unit (PIU), placed within the Ministry of Public Health. The PIU will be tasked to support the day-to-day project management, including the fiduciary tasks, procurement and monitoring and evaluation (M&E).

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SAFEGUARDS

A. 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. No construction of health centers ort other physical structures expected at this point.

B. Borrower's Institutional Capacity for Safeguard Policies

Guinea-Bissau has an established regulatory and institutional framework that ensure the integration of environmental and social considerations at the project and program level. The Ministry of Environment and Sustainable Development is responsible for the enforcement of the environment assessment legislation and procedures, through the Competent Environmental Assessment Authority (AAAC). However, AAAC has limited staff and is only present in Bissau. Adequate measures will be taken by the project to ensure the safeguard instruments of the proposed project be implemented efficiently

C. Environmental and Social Safeguards Specialists on the Team

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

D. 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	
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.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Dec 05, 2017

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

The MWMP is expected to be completed and disclosed by December 2017

CONTACT POINT

World Bank

Edson Correia Araujo

Senior Economist

Borrower/Client/Recipient

Ministry of Economy and Finances
Joao Alage Mamadu Fadia
Minister
joaofadia@hotmail.com

Implementing Agencies

Ministry of Public Health
Van Hanegem Menezes Moreira
Diretor Geral da Administracao do Sistema da Saude
moreira.vany8@gmail.com

FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects

APPROVAL

Task Team Leader(s):	Edson Correia Araujo

Approved By

Practice Manager/Manager:	Gaston Sorgho	22-Sep-2017
Country Director:	Kristina Svensson	08-Dec-2017

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