PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED INTERNATIONAL DEVELOPMENT ASSOCIATION CREDIT

IN AN AMOUNT OF SDR 8.6 MILLION

TO

THE REPUBLIC OF GUINEA-BISSAU

FOR A

NATIONAL HEALTH DEVELOPMENT PROGRAM

October 21, 1997
CURRENCY EQUIVALENTS
(July 1997)
Currency Unit = CFA Franc (FCFA)
US$1.0 = 580 FCFA

FISCAL YEAR
Government Fiscal Year: January 1 - December 31

WEIGHTS AND MEASURES
Metric System

ABREVIATIONS AND ACRONYMS

AGEOPPE ................. Agency for Employment Creation
AfDB ..................... African Development Bank
CSA ...................... Health Center Type A
CSB ...................... Health Center Type B
DAF ....................... Direção de Administração do Finanças (Directorate of Administration and Finance)
DGPC ..................... Direção Geral de Planejamento e Cooperação (General Directorate of Planning and Cooperation)
DGSP ..................... Direção Geral de Saúde Pública (General Directorate of Public Health)
DRH ....................... Direção de Recursos Humanos (Directorate of Human Resources)
GOGB ..................... Government of Guinea-Bissau
HIS ....................... Health Information System
HMMDP .................... Health Manpower Development Plan
HN3A ...................... Third of August National Hospital
HNSM ...................... Simao Mendes National Hospital
IAPSO .................... Inter-Agency Procurement Services Office (a U.N. agency)
IDA ....................... International Development Association
IEC ....................... Information, Education and Communication
MINNE .................... Ministry of National Education
MOPH ..................... Ministry of Public Health
NHDP ..................... National Health Development Program
NMS ....................... National Medical School
PCU ....................... Program Coordinating Unit
PHC ....................... Primary Health Care
PIP ....................... Public Investment Program
PPF ....................... Project Preparation Facility
PY ....................... Project Year
SAF ....................... Social Action Fund
SBD ....................... Standard Bidding Documents
SCC ....................... Systematic Client Consultation
SIP ....................... Sector Investment Program
SOE ....................... Statement of Expenditures
SOLIDAMI ................. Solidarity and Friendship Institution
STIs ....................... Sexually Transmitted Infections
USBs ....................... Basic Health Units
VHU ....................... Village Health Units

Vice President .................. Jean-Louis Sarbib
Country Director ................. Mahmood A. Ayub
Sector Manager .................. Ok Pannenborg
Task Team Leader ............... Tonia Marek
Task Team Assistants .......... Resident Mission: Marie-Madeleine Ndaw
Headquarters: Rudi Chevannes
Guinea-Bissau
National Health Development Program

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### Project Appraisal Document

**Guinea-Bissau**

**National Health Development Program**

**Date:** October 21, 1997

**Task Manager:** Tonia Marek

**Country Director:** Mahmood A. Ayub

**Project ID:** GW-PE-35688

**Sector:** Population, Health and Nutrition

**Lending Instrument:** Specific Investment Loan (SIL)

**PTI:** [ ] Yes [ ] No

### Project Financing Data

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**For Credits/Others:**

**Amount:** US$11.7m/SDR8.6m

**Proposed Terms:**

- **Multicurrency:** [X]
- **Single currency:** [ ]
- **Standard Variable:** [X]
- **Fixed:** [ ]
- **LIBOR-based:** [ ]

**Grace period (years):** 10

**Years to maturity:** 40

**Commitment fee:** 0%

**Service charge:** 0.75%

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<tr>
<td>NGOs, WHO, and others</td>
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**Total**

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**Borrower:** Republic of Guinea-Bissau

**Guarantor:** N.A.

**Responsible agency:** Ministry of Public Health (MOPH)

**Estimated disbursements (Bank FY/US$m):**

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### For Guarantees:

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### Terms of financing:

- Principal amount (US$)
- Final maturity
- Amortization profile
Country: Guinea-Bissau

Project Title: National Health Development Program

Financing available without guarantee?: N.A. [ ] Yes [ ] No

Expected effectiveness date: March 02, 1998
Closing date: December 31, 2003

Block 1: Project Description

1. Project development objectives (see Annex 1-A for key performance indicators):

The overall objective of the National Health Development Program (NHDP) is to improve the health status and well-being of the population, particularly of women and children, through a strengthening at all levels of the national health system, including health services and facilities, and management structures and processes. Specific objectives are (i) to increase the use and effective coverage of primary health care services and referral centers; (ii) to strengthen the institutional capacity at all levels; (iii) to improve the quality and the management of human resources; and (iv) to reinforce intersectoral coordination and action in health-related activities in order to promote better health among the population.

2. Project components (see Annex 2 for a detailed description and Annex 3 for a detailed cost breakdown in local and foreign expenditures):

<table>
<thead>
<tr>
<th>Component</th>
<th>Category</th>
<th>Cost Incl. Contingencies (US$M)</th>
<th>% of Total</th>
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<td>(2) Strengthening of institutional capacity at all levels (central, regional and local)</td>
<td>Management, institutional</td>
<td>12.8</td>
<td>19</td>
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<tr>
<td>(3) Management and development of human resources</td>
<td>Institutional, policy</td>
<td>12.6</td>
<td>19</td>
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<td>(4) Promotion of better health</td>
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<tr>
<td>Total</td>
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3. Benefits and target population:

Benefits. The National Health Development Program (supported by the IDA credit) will increase the coverage and quality of health services in the country, will improve equity in access to the services, will ensure a shift of resources toward rural areas, and will provide a minimum package of health care. The main beneficiaries of improved health facilities will be women and children through MCH programs. The incorporated AIDS prevention aspects of the Program will help slow the spread of HIV infection and alleviate the burden of HIV/AIDS on individuals, families and the nation. The Program will help improve the effectiveness of family planning activities through increased availability of services, better training and supervision, and through regular monitoring of impact indicators. It will also generate important external benefits by assisting the MOPH in the coordination and implementation of projects undertaken by all donors. Finally, the Program will assist in increasing the transparency and efficiency of the sector’s budgetary process by moving virtually all off-budget health expenditures into the budget.

Target population. The beneficiaries of the current basic health services are women and children. The Program is aimed at strengthening the health system, particularly for the poorer segments of the population. The focus on basic and preventive care, emphasized by the National Health Development Program, ensures that components aimed at improving pharmaceuticals, medical supplies, and health staff training will reach the poor. Improved services to the poor respond to the human resource development and poverty alleviation objectives of the Government.

Form _____
4. Institutional and implementation arrangements:

Implementation period: Six years

Executing agency: Ministry of Public Health (MOPH)

**Project management:** The MOPH, through its directorates and line agencies, will have overall responsibility for the management of all program activities. See Annex 2 for the implementation arrangements for each component and sub-component. The General Directorate of Public Health (*Direcção Geral da Saúde Pública - DGSP*) and its various directorates, the Directorate of Human Resources (*Direcção de Recursos Humanos - DRH*), regional health teams, health centers, referral centers and specialized institutions will be responsible for all operational aspects of the program. The General Directorate of Planning and Cooperation (*Direcção Geral de Planificação e Cooperação - DGPC*) and its various directorates will be responsible for planning, monitoring and evaluation, administrative and financial management, and the coordination of external assistance. The DGPC will be strengthened with a public health specialist, a health economist, an expert in accounting and financial management, and a program manager. The Program manager in particular will assist the Directorate of Administrative and Financial Affairs (*DAF*) in DGPC to ensure that everything is done by the responsible directorates of MOPH to comply with the requirements of all donors regarding procurement, disbursements, accounts, audits, progress reports, and annual and mid-term reviews. The role of each directorate within the MOPH in the implementation of the program, and the relationships between them, will be detailed in the Program Implementation Manual under preparation. The finalization of the Program Implementation Manual is a condition of credit effectiveness.

**Project oversight:** Policy guidance and coordination between the two General Directorates of the MOPH will be provided by the Minister. In addition, a Management Committee (*Comité de Gestão*) consisting of the two Director Generals and others will participate in program planning and monitoring. This committee will approve the annual programs, review progress in all program activities, and monitor performance indicators.

**Accounting, financial reporting and auditing arrangements:** The DAF (*Direcção de Administração e Finanças*) in the DGPC will be responsible for program administrative and financial management and reporting, including arrangements for audits, following systems and procedures acceptable to IDA. Records will be kept for all program-related expenditures and financing following normal budgetary procedures. A special account for the IDA credit will be opened and maintained with a commercial bank, acceptable to IDA; it will be managed by the DAF and the Program manager. An independent auditor acceptable to IDA will audit the use of all IDA funds applied in financing the program, including the IDA special account and statements of expenditures. Audit reports will be submitted no later than six months after the end of the financial year. The auditor’s terms of reference were agreed upon with IDA during negotiations, and the appointment of the auditor will be a condition of effectiveness of the IDA credit. Under the program, the DAF will be strengthened by the long-term technical assistance of an expert in accounting and financial management in order to appropriately maintain the program accounts, including those of the IDA credit.

**Monitoring and evaluation arrangements:** Under the overall guidance of the Management Committee, the monitoring and evaluation of the program will be the shared responsibility of the MOPH directorates, with the particular involvement of the Directorate of Planning (*Direcção de Planificação - DP*) in DGPC and its Division of Information and Statistics (*Serviço de Informação e Estatística - SIE*) and of the Epidemiology Department (*Epidemiologia*) in DGSP. As the National Health Development Program (NHDP) shifts from a project-based program to a multiple-activity program, centered around unifying objectives and specific activity lines, supervision processes will also be undertaken according to these integrated activities. Supervision missions by donors, annual progress reviews, and the mid-term review will be organized so as to minimize their demand on the already scarce work force of the MOPH. Monitoring procedures and program progress reports will focus on progress in and impact of the implementation of the NHDP, measured against specific targets (see indicators in Annex 1-A) and actions set in the two-year rolling plans and detailed implementation programs, all of which will be reviewed and revised each year during the annual review throughout the life of the program. General progress of the program will be measured against a list of key indicators, which are included
in the Program Design Summary (Annex 1-A), the Letter of Health Sector Development Policy (Annex 1-B), the NHDP itself and the Implementation Plan in the Program Implementation Manual. The monitoring and evaluation of some of those indicators will be conducted through specific surveys (e.g., contraceptive prevalence surveys) and beneficiary assessments. In addition, each year the MOPH will update the two-year rolling plan and will prepare the work programs and the investment and recurrent budgets for the next year and discuss them with the donors. Following these discussions, donors will express their expected commitments to the various program components for the following year, and IDA funds will be reallocated to finance any gaps in priority areas. At end June 2000, a midterm review of the Program will be carried out in accordance with terms of reference and monitoring indicators acceptable to IDA and other major donors. In addition, the MOPH will submit to IDA and other donors simple, agreed-upon, semi-annual progress reports summarizing the status of each component and the degree of compliance with donor covenants and agreements. The format of these reports will be designed to fulfill the MOPH needs for summary information for decision making and will also be adapted to satisfy IDA’s and other donors’ reporting requirements. Within six months of the closing of the IDA credit, an Implementation Completion Report will be prepared by IDA, with MOPH contributing its own evaluation of the Program.

Block 2: Project Rationale

5. CAS objectives supported by the project: to assist Government in stepping up reforms and focusing on poverty reduction, in particular through accelerating economic growth and shifting resources to rural areas and to human resource development.

IDA’s Country Assistance Strategy (CAS) to Guinea-Bissau is structured around the following main elements: promotion of macroeconomic stability, development of human resources, support to private sector development, and reduction of the debt burden. The development of human resources involves providing assistance to education and health to improve and expand services, with a focus on primary services delivery and rural areas, aiming to decrease extreme poverty and to improve the situation of women, and promoting the involvement of non-government entities in service delivery. IDA operations will also emphasize sectoral reforms to improve the adequacy of the relevant policy framework, support local capacity building and utilization, involve the participation of beneficiaries and stakeholders in program design and implementation, and encourage donor coordination. Economic growth is fundamental to poverty reduction in Guinea-Bissau because the country is too poor to rely only on redistributive policies for sustained poverty reduction. How growth is achieved will also affect poverty. In Guinea-Bissau, a poverty reducing growth pattern will involve a shift of resources and opportunities from urban areas to rural areas where the poorest populations live. The programs required to implement this strategy need considerable external financial support and a strong Government commitment. The National Health Development Program (NHDP) is a central part of this assistance strategy. It is also consistent with IDA’s human resources development and poverty alleviation objectives in the Sahel, as well as with its AIDS prevention strategy. Finally, the program would provide a framework for enhanced donor coordination for the health sector.

6. Main sector issues and Government strategy:

Background on morbidity and mortality: Guinea-Bissau’s population of 1.1 million has very high rates of mortality and morbidity, even by African standards. Infant mortality is estimated at about 138 per thousand live births, compared to 92 for Sub-Saharan Africa. Child mortality under 5 years of age is estimated at over 240 per thousand. Immunization levels are low, with only 45% of children immunized against DPT, and 30% completely vaccinated by their first birthday. Sanitation, including basic latrines, is available to less than one third of the population. Malaria is the main cause of recorded morbidity and the leading cause of infant deaths. Severe diarrhea is the second cause of infant deaths. The prevalence of sexually transmitted diseases estimated at 25% among adults. Prevalence of HIV2 among adults is about 10%, the highest in the world (the HIV1 epidemic is much more recent). It is estimated that in the capital city 12% of women use contraception, while this rate is 5% in secondary cities and only 1% in rural areas. A resurgence of tuberculosis has also been noted in Guinea-Bissau.
Main Sector Issues: Four major issues need to be addressed to improve the performance of the health sector:

- First, a weak sector policy framework and inadequate implementation programming and execution capability.

- Second, inadequate health manpower planning, development, deployment and management, including the lack of supervision. The number, composition and uneven geographical distribution of health personnel, as well as the lack of an incentive system, are growing concerns. There is a serious shortage of midwives country-wide, a deficit of physicians in the regions, and a surplus of physicians in the capital.

- Third, poor financial resource allocation and management. The present level of funding is inadequate to sustain even minimal health care for the highest priority health problems. Moreover, the allocation of available resources among health facilities and people throughout the country (with relatively too much money spent on drugs for the national hospitals and not enough for the regions) is not appropriate.

- Fourth, limited revenue raising or cost-recovery.

7. Sector issues to be addressed by the project and strategic choices:

During preparation of the NHDP several urgent decisions were considered as prerequisites to a successful implementation of the program. Some of these decisions were taken in March 1997 (see details in section 11), but the question of low-level salaries and their late payment still need to be addressed in the broader context of civil service reform and structural adjustment. Nonetheless, the program proposes some incentives for health personnel. The major donors and technical agencies in the country agree with the MOPH that the health services system needs to be strengthened, placing a strong focus on effective coverage of the population with a package of high impact, cost-effective basic level services, as stated in the Letter of Health Sector Development Policy (Annex 1-B). The NHDP, described in more detail in Annex 2, addresses the following four major health sector issues:

(1) Weak sector policy framework, inadequate implementation programming and execution capability. The Sector Investment Program (SIP) provides more rational sector-wide programming. The annual programming will also allow for monitoring of outcomes and better utilization of resources. The SIP approach will foster a more effective use of donor funding and a better coordination of planning and management resources (financial and human). At the central level, the NHDP will improve program planning, implementation, monitoring and evaluation, supervision, administration and financial management, including the development of an Integrated Health Sector Information System, and the procurement and distribution of essential drugs, with special emphasis on the preparation and monitoring of annual work programs and budgets (expected to be a rolling two-year plan within a defined longer-term framework of five years). At the regional level, the NHDP will enable health services and facilities to function properly following the decentralization of health care services and their management.

(2) Inadequate health-staff planning and management. During the preparation of the NHDP, the MOPH developed a detailed staff deployment plan. The Health-Staff Development Program is based on health center mapping, the minimum package of activities by level, quality of care, and available resources (in terms of salaries). This planning exercise led to the development of personnel norms (number and type of personnel needed by level of infrastructure). The main priorities of the NHDP in this domain are (i) redistribution of personnel; (ii) improvement in working conditions; (iii) better training, more focused on quality than quantity; (iv) strengthening of the MOPH Department of Human Resources capacity as well as computerization of the health manpower information system. Of the approximately 2250 personnel working for the MOPH in 1996, around 20% will leave the MOPH (including voluntary departees) during the Plan period, and the rest will be redeployed and trained. Emphasis will be placed on providing sufficient well-trained nurses and midwives for health centers and regional hospitals. The new emphasis on integrated
supervision and focus on results, which the NHDP is introducing should improve personnel motivation and performance.

(3) **Poor financial resource allocation and management.** the NHDP plans to address this issue by containing costs and increasing value for money as follows:

- the NHDP’s budget will ensure that public health resources shift from curative to preventive care by increasing the share of financial resources going to the regional levels (for primary and some secondary care) from 25% to 53%;

- A cost-effective package of health services has been designed (through the Minimum Package of Health Services) as the building block for the whole NHDP. An analysis of the NHDP budget shows it is well within the recommended norm for Africa (according to the World Bank’s strategy paper “Better Health for Africa”) for this package of basic services: basic services will cost US$4.50/person/year for primary care, regional hospitals and district teams. If this figure is adjusted for the relatively low salary levels in Guinea-Bissau, the NHDP would cost US$6.75/person/year, not too far below the US$8.15 figure for Sub-Saharan Africa. This basic minimum package of cost-effective integrated preventive and curative health services will be provided in health centers accessible to a majority of the population, with community outreach (through the Basic Health Units, USB) and with effective support and supervision by regional health (equivalent to health district) teams. Central support and supervision, now provided through national programs (e.g., AIDS, maternal and child care, and family planning), will be coordinated at the national level and integrated at the regional and peripheral levels.

- The national hospital, leaving primary care to the improved primary care facilities, will become more efficient. For example, in the Autonomous Sector of Bissau (the health district covering the capital city, with an expected population of 300,000 by the year 2000), more health centers will be built and staffed to ensure that the national hospital, Simao Mendes will gradually receive more referred cases and less primary care cases.

- More effective use of donor funding: before the development of the NHDP, the MOPH could keep proper account of health expenditures, because many of the health-related budgets were managed by donors or project units outside the MOPH. It was estimated that in 1996 alone about US$3 million were invested in the country without being included in the public investment program (PIP). This would amount to an unaccounted $15 million over the five year PIP! The NHDP will establish a common budget, thereby allowing the MOPH to better gauge and use available resources, while reducing reporting requirements.

(4) **Limited revenue raising or cost-recovery.** Although one district has been implementing the Bamako Initiative since 1989 on a pilot basis, no further action was taken until recently (March 1997) to broaden this experience. In March 1997, the Council of Ministers finally approved texts for the implementation of the Bamako Initiative. The NHDP will implement cost-recovery at the health center level through the Bamako Initiative system with local community committees. A text was also adopted in March 1997 establishing a cost-recovery system which will be implemented at the hospital level.

8. Project alternatives considered and reasons for rejection:

The SIP approach was selected over a regular investment project approach because (i) the MOPH has exhibited leadership and ownership through its recent preparation of a National Health Development Program (NHDP); (ii) the country is small with one major hospital, so a sectoral program approach is not unduly complicated; (iii) other donors have expressed interest in collaborating with the Government and IDA on the SIP to ensure better coordination; this donor involvement is an essential requirement for the sectoral approach; and (iv) the recent CAS strongly recommended this approach which will allow for better use of scarce human and financial resources. Although MOPH capacity has
improved significantly over the last three years, it is still weak, and the SIP approach will further reinforce the capacity of current MOPH services. This will be an improvement on the present project management which is separate from the MOPH and provides it with limited institutional reinforcement in terms of management. In addition, the construction and rehabilitation of health facilities financed by the IDA credit (and possibly by other donors) will be carried out by AGEOPPE, an implementing agency for civil works. Procurement will be handled by the strengthened procurement unit (DAF) in DGPC with the assistance of the Program manager. In order to reduce the workload of DAF, the procurement of imported equipment (including vehicles) may be done through IAPSO (UN Inter-Agency Procurement Services Office), and procurement of drugs will be done through UNIPAC or another specialized procurement agency. Private contractors and consultants (under contracts with AGEOPPE) will execute the construction and rehabilitation of infrastructures. The private sector will also be involved in the social marketing of condoms and mosquito nets.

9. Major related projects financed by the Bank and/or other development agencies (completed, ongoing and planned).

IDA’s involvement in the health sector in Guinea-Bissau is relatively recent. It began with the Population, Health and Nutrition (PHN) Project (Cr. 1800-GUB for US$4.2 million equivalent, approved in May 1987 and closed in December 1991). This project’s objectives were to improve the institutional capabilities of the Ministry of Public Health (MOPH) in planning, management, and finance, and to strengthen the delivery of health and family planning services at the periphery. The multi-sector Social and Infrastructure Relief Project (SIRP) (Cr. 2020-GUB for US$5.0 million equivalent, approved in 1989 and closed in June 1993) had a health component which built on the first project in providing essential inputs and improving physical infrastructures. The ongoing Social Sector Project (SSP) (Cr. 2465-GUB for US$8.8 million equivalent, approved in 1993 and scheduled to close on December 31, 1997), whose objective is to assist the Government in improving the delivery and quality of primary health care for a wider base of the population, has both a social action fund and a major health component. That component includes the rehabilitation and equipment of health centers and health posts, the upgrading and training of health professionals, and inputs to coordinate and strengthen the delivery of IEC activities. These projects have given IDA the experience to act as a catalyst in helping coordinate donor involvement, influencing sector policies, and supporting institutional development in the sector.

In its final evaluation, the first IDA operation in the health sector, the PHN Project, was deemed overly ambitious in its attempt to address a wide array of problems affecting the health sector, particularly in light of the limited capacity of the country. In a number of areas it failed to meet the original project objectives. OED/PCR ratings were “unsatisfactory” for outcome, “unlikely” for sustainability and “negligible” for institutional development. The project did, however, develop elements of an appropriate framework for future efforts which should have lasting effects on the health sector including: beginning the institutionalization of the policy and practice of cost-recovery in the sector; initiating a model for supervising rural health services which has contributed to strengthening the regional health systems management process; improving drug system management; and undertaking policy studies in family planning and nutrition, as well as the first demographic health survey (DHS) in the country which will contribute to strengthening the health data base. At its close, the PHN project was completely disbursed. The implementation of the Social and Infrastructure Relief Project has been satisfactory; it has opened new perspectives for private sector involvement in a number of sectors including health. OED/PCR ratings were “satisfactory” for the outcome, “uncertain” for sustainability and “substantial” for institutional development. The Social Sector Project had a slow start, but is now being implemented satisfactorily. However, there are still problems with intersectoral coordination (particularly for the IEC component) and with the assignment of health personnel trained under the project. Also, the social fund component suffers from a lack of experienced NGOs and associations, and there is a need for a preselection and training of existing NGOs and associations. For that project, both the IP and the DO ratings are “Satisfactory”. Typically, projects in the health sector have experienced problems resulting from limited implementation capabilities and insufficient local funds, as well as lack of coordination among donors.

Among other donors, UNFPA has an ongoing program to improve the utilization of family planning services. UNICEF has promoted the Bamako Initiative. AfDB is planning to participate in the financing of the NHDP. Denmark has supported primary health care in the regions of Biombo and Oio. France finances primary health care in the region of Oio and the proposed Mansoa hospital; it is interested in increasing its support for the sector within the NHDP. The
Netherlands have put a major emphasis on community-based health care and support for the management capacity of the regional health teams in four regions (Tombali, Quinara, Cacheu and S.Domingos). They have also provided financing for an essential drugs component for those four regions, which includes fellowships and technical assistance. Finally they have offered support for the creation of the National Health School, and they are very interested in financing the NHDP. Sweden has financed MCH and FP services and provided support for the National Public Health Laboratory. In addition to supporting some vertical programs, WHO has supported management strengthening at regional levels and provided financing for the medical faculty.

10. Lessons learned and reflected in the project design:

The Implementation Completion Reports on IDA projects in the health sector in Guinea-Bissau list a number of lessons learned from those completed operations. These are related to (i) MOPH’s weak implementation capacity (including the importance of proper component selection and preparation, the need to tailor technical assistance to the borrower’s absorptive capacity and to supervise it closely, and the importance of having project management units helping in institution building and of having national counterparts involved in project preparation and start-up activities with some continuity in staffing); (ii) the importance of having counterpart funds available on a timely basis; and (iii) adequate coordination among donors. Lessons learned from health project experiences elsewhere indicate that it is possible to improve overall efficiency by program integration, and that a basic package of cost-effective health services (requiring the presence at the base level of a number of critical elements including, inter alia, trained personnel, essential drugs, and support from the next levels) can contribute to improving the health status of the population. All these lessons have been taken into account in the design of the National Health Development Program, with its emphasis on institutional the integration of health services, the need for a better allocation of human and financial resources within the sector, appropriate technical assistance and a better coordination among donors. Flexibility on the part of IDA as to yearly programming of resources for the health sector to better accomplish the program’s objectives and to contribute to a longer term and broader view of the sector’s support and development will be especially important under the NHDP. In addition to being more responsive to borrower needs, it will also contribute to improved donor coordination.

11. Indications of borrower commitment and ownership:

The MOPH has been seriously preparing the National Health Development Program since 1995 and has recently made some strategic appointments for higher level positions in MOPH. In March 1997, the Council of Ministers approved the following two measures:

(a) the text creating the statutes of a national health school (combining the existing medical school, paramedical school and on-the-job training program in order to maximize use of resources);

(b) all the texts for the implementation of a cost-recovery system for drugs and services through the Bamako Initiative system at the health center level.

In addition, the Government has improved the availability of counterpart funds for the ongoing Social Sector Project (the first deposit requested for 1997 of about US$42,000 was made in April 1997, as recommended by the last supervision mission).

The documents presented by the NHDP at the Health Sector Round Table organized by the MOPH in June 1997, were well-prepared and thorough, reflecting a high level of political commitment to the work as did the fact that the President of the Republic himself closed the workshop.

12. Value added of Bank support:

The preparation of the NHDP was complemented by two other Bank instruments, namely the Country Assistance Strategy (CAS) and the Public Expenditure Review (PER), which helped to integrate the NHDP more systematically into the overall country strategy. The Government requested the Bank’s technical advice in designing its National Health
Joint missions with other major donors, led by the Bank, have provided support to the sector-wide approach chosen by Government, and these multi-donor missions have worked in complete partnership with MOPH providing them with necessary technical inputs. The Bank has encouraged other donors to join into the program as a guarantee for quality and transparency of the process.

Block 3: Summary Project Assessments (Detailed assessments are in the project file. See Annex 8)


Others:
- distribution between capital and recurrent costs and;
- best practices (see Annex 4).

A partial cost-effectiveness analysis was undertaken (see below). The economic analysis is currently based on the “best practice” analysis.

a) Cost-effectiveness

A partial cost-effectiveness analysis (see Annex 4) was undertaken and will be monitored during the NHDP implementation. The analysis is based on the present situation characterized by a low current utilization rate of services, a population growth rate of 2.1 percent and an utilization rate increase of health services of 50% over the 1997-2002 period. Under these assumptions, the cost per inhabitant will increase slowly from around US$4 to US$4.6 over the program period, although an increase in effectiveness is expected to be achieved. During the period, the cost per unit of activity (measured by the number of new cases treated in the District) is expected to decrease from around US$14.5 (frequency rate of 0.275 new cases/inhabitant/year) to around US$11.8 (frequency rate of 0.375 new cases/inhabitant/year).

In the case of a theoretical “good” utilization rate of services (0.5 new cases/inhabitant/year, which is a long term objective), compared to the norm which the Bank uses in “Better Health in Africa” (BHA), the NHDP costs for primary care services to be provided seem to be within acceptable levels. The NHDP points to a cost of US$4.49/person/year which compares favorably to US$8.15/person/year for BHA. The difference is primarily due to the relatively low salaries in Guinea-Bissau. The average civil service wage in Guinea-Bissau is about one sixth of the West African Economic and Monetary Union (UEMOA) average. For comparison purposes, if the salary component of the NHDP is multiplied by 6, the NHDP cost/person/year would reach US$6.75, much closer to the BHA norm.

The overall NHDP budget (including tertiary care and all central level expenses) represents about $12/person/year (which remains much below the $14 for sub-Saharan Africa - in 1990 dollars)

b) Fiscal impact

The NHDP recurrent costs are estimated to increase by 5% annually over the estimated 1996 total health sector recurrent expenditures (US$2.5 million). In terms of capital expenditures, an increase in the allocation of resources is also expected to take place. While during the period 1994-96 the health sector has represented, on average, about 12 percent of the PIP, for the period 1998-2002 this share is projected to move to about 15 percent.

c) Linkage to PER, PFP and CAS:

The Public Expenditures Review in the health sector (World Bank Report No. 14903-GUB, November 1996) showed that the sectoral issues identified (ref. to Block 2, section 7) were the ones to be tackled. In addition, the
PER indicated that up to then the MOPH budget was not based on an analytical assessment of needs nor of their relative priorities. This is what the NHDP aims at achieving by changing the focus from curative to preventive care. The NHDP proposes reallocating resources so that the share of the health sector budget going to primary care and first referral centers will increase from 25% to 53%. The increased emphasis on primary care will be associated with better services to the poor, mainly because of the emphasis on service delivery at the regional level. The PER also indicated that about 60% of investments in 1994 went to foreign technical assistance. This is a situation the NHDP is trying to remedy by (i) identifying the real needs for T.A. and defining terms of reference that will be submitted to donors (Year 1 of the NHDP, T.A. represents 29% of the total budget, but it decreases to 14% in Year 5); and by (ii) providing a unique consolidated sectoral program so that donors can complement each other. The risk is that certain donors will continue to invest heavily in the health sector but only for T.A. and activities which are not part of the NHDP (its own research agenda, for example). For example, one donor spends about US$2.5 million/year on just the hospital of Canchungo. The MOPH is aware of this problem and will discuss it with donors to correct this less than optimal approach to country assistance.

(i) The recently negotiated Policy Framework Paper (1997-99) indicates that health expenditures as a share of the Government current budget, excluding interest payments, should be maintained at 11% over the project implementation period. In the recent past, the share of government current expenditures spent on the health sector has ranged between 10 and 10.5 percent. Provided the Government meets this commitment, resources will be sufficient to meet the recurrent spending requirements of the NHDP.

(ii) The NHDP is consistent with the Bank's Country Assistance Strategy (CAS) of putting in place policies and programs to reduce poverty and to improve the unacceptably poor indicators of social development. Moreover, as underlined in the CAS, it emphasizes improved access to better quality of health services, especially to women, the poor and to the rural areas.

14. Financial Assessment (see Annex 5) [NPV: N/A; FRR: N/A (not a revenue earning project)]

- The total cost of the five-year NHDP is estimated at US$66.1 million, of which 62% for investment costs and 38% for recurrent costs.

- The Government budget would finance US$13 million (19% of the total), or US$2.5 million per year, which is the amount of financing actually provided by Government in the last few years for the MOPH recurrent budget. Most of the domestic contribution originated from counterpart funds generated from balance of payment support.

- Beneficiaries would contribute US$4.5 million (7%) and other donors would finance US$36.9 million (56%).

- As a lender of last resort, IDA would finance US$11.7 million (18% of the total NHDP budget).

- For the Government to be able to provide its contribution, the proportion of its recurrent budget dedicated to health should be about 11%, a slight increase compared to the 10%-10.5% range of the last few years. As in the past, the bulk of the financing would continue to come from donors. Historically, the largest proportion of external funding has been spent on investment (about 50-60%), technical assistance (10-15%) and training (about 5%), so that only 20-25% of external funds have been spent on the direct delivery of health care. Also, inflation has been a problem resulting in a continuing erosion of salaries of health personnel. Regarding inflation, the situation should improve following the recent entry of Guinea-Bissau into the UEMOA (CFA franc zone), with the major fiscal belt-tightening that such a move entails. The NHDP will address the problem of the overall lack of funds (from both national and external sources) for direct delivery of health care, with a better allocation of resources throughout the country and a new financing strategy that increases private sector contributions, as well as contributions from external sources and, to the extent possible, from the Government budget. Community-based financing schemes have been tried in Guinea-Bissau with varying degrees of success. They include the “Abota” system (a type of cooperative or group of individuals that pool funds for purchasing essential drugs with a pre-payment system) and the Bamako Initiative plan in the Gabu
Project Appraisal Document  
Country: Guinea-Bissau  
Project Title: National Health Development Program

Region (with the support of UNICEF and The Netherlands) aimed at improving the quality of local services and ensuring the availability of essential drugs. The NHDP envisages the progressive implementation of the Bamako Initiative in all regions. Regarding the allocation of resources within the sector and particularly between the four main components of the program, about 60% of the program cost is for increasing coverage by primary health care centers and by referral centers, 18% for the strengthening of institutional capacity at all levels, 21% for the management and development of human resources, and 2% for the promotion of better health.

Although the Government managed to finance a significant percentage of expenditures for the health sector through the use of counterpart funds generated from balance of payment support, availability of counterpart funding for individual projects financed by donors and the payment of salaries and allowances to health personnel have always been a problem. Regarding salaries and allowances, the Government has decreed that payment of social sectors civil servants' salaries is a priority. The MOPH and the Ministry of Finance prepared a detailed plan for timely payment which has been in effect (with social sector civil servants receiving payments on time) since August 1997.

15. Technical Assessment:

The NHDP is technically sound. The issues of access and equity are addressed in a systematic manner on the basis of needs, opportunities and comparative advantages within the context of the poverty agenda.

The preparation of program components is based on international as well as regional norms and practices, and the program will be carried out in accordance with acceptable standards. Innovations, such as community financing and regional planning, are based on sound technical, financial and economic considerations. Investment and recurrent cost estimates for the program are based on estimates of prevailing market unit costs. A major issue is the emerging AIDS epidemic and the level of commitment of the Government of Guinea-Bissau to fight this disease. An effort was made to sensitize high-level Government personnel, with related public IEC and social marketing activities funded under the ongoing Social Sector Project. Work on the NHDP fostered discussion and heightened consciousness of AIDS issues and of the urgent need for more effective action. AIDS activities will be tailored and redirected in light of the government’s absorptive capacity and commitment. The population growth rate is also an issue. Program activities which will contribute directly or indirectly to supporting family planning efforts include the integration of family planning services and support in the minimum package of primary health services, the social marketing of condoms, IEC on responsible parenthood and responsible sex, and training of health staff on sexual behavior and counseling.

16. Institutional Assessment:

a. Executing agencies: The MOPH has demonstrated that, with the assistance of donors and consultants, it can formulate a National Health Development Program. Nevertheless, the weak absorptive and implementation capacity of the MOPH (including generally low capacity, efficiency, functioning and utilization of health services and personnel) remains a widely recognized issue. Also, the MOPH may have difficulty implementing its personnel redeployment plan. The NHDP will help improve the situation through emphasis on a program approach, on integrated services at the periphery and on the need to focus on impact at local level, as well as through appropriate technical assistance and training to increase capacity, including in the areas of planning, coordination, supervision, monitoring and evaluation, at all levels. In order to make it more attractive for health personnel to work at the periphery, incentive systems based on better housing and working conditions have been incorporated into the program.

b. Project management: The management capacity of the MOPH is weak. The NHDP will strengthen it, and measures have been (or will be) taken to strengthen program management, reduce the procurement and accounting burden that the NHDP will impose on the MOPH, and facilitate donor coordination. These measures include (i) the appointment of a Program Manager in the Directorate for the Coordination of External Assistance (DCAE) in DGPC; (ii) technical assistance to be provided to the Directorate of Planning (DP) in DGPC by a public health specialist and a health economist; (iii) installation in the Directorate of Administration and Finance (DAF) of an accounting system acceptable to IDA and recruitment of an expert in accounting and financial management; (iv) delegation to AGEOPPE of the
management and execution of the construction/rehabilitation of health infrastructures financed by the IDA credit, and
possibly by other donors; and (v) the use of UN Agencies and other non-profit organizations for the procurement of most
goods: procurement of vehicles and equipment through IAPSO, and procurement of drugs, vaccines and contraceptives
through UNIPAC or through other non-profit organizations (such as International Dispensary Association - IDA - in the
Netherlands).

17. Social Assessment:

Since the ultimate objective of the NHDP is the improvement of the health status and well-being of the population in
general, and of women and children in particular, the NHDP will have a very positive social impact. It will promote the
provision of good quality health care to the majority of the population through an improvement in the effective coverage
of the “minimum package” of care at the health center level, coupled with improved access to good quality referral care.
It will also ensure a greater share of budget resources to the health sector and improve their allocation to emphasize,
\textit{inter alia}, fairness in the distribution of resources and equity in the access to health care across regions and social groups.
The NHDP —in addition to benefiting the majority of the population—includes activities such as information campaigns
and grassroots level actions that will reinforce the social acceptability of the program.

18. Environmental Assessment:

This is a category C project, since no environmental risks are foreseen. Any construction/rehabilitation of buildings will
be done in accordance with acceptable standards. Promotion of hygiene will have a positive environmental impact.
There would be no displacement of people.

19. Participatory Approach:

<table>
<thead>
<tr>
<th>Identification/Preparation</th>
<th>Implementation</th>
<th>Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>CON &amp; COL</td>
<td>CON &amp; COL</td>
</tr>
<tr>
<td>Beneficiaries/community groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediary NGOs</td>
<td>CON</td>
<td>CON &amp; COL</td>
</tr>
<tr>
<td>Academic institutions</td>
<td>COL</td>
<td>COL</td>
</tr>
<tr>
<td>Local government</td>
<td>COL</td>
<td></td>
</tr>
<tr>
<td>Other donors</td>
<td>IS &amp; COL</td>
<td>COL &amp; IS</td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. Sustainability:

The Program builds upon the ongoing Social Sector Project (Cr. 2465-GUB), which includes infrastructure, IEC, training
and (community/NGO) social fund activities and in which a pilot operation for social marketing of condoms began in
November 1995. The sustainability of the program will be helped considerably by the sector approach and the close
coordination envisaged among the key donors. Other factors which would help are (a) Government’s acceptance of a
redefined role and to provide continuous support to the regions; (b) use of beneficiary assessments for yearly
reprogramming; and (c) transparency in allocation and management of resources. The MOPH explicitly designed the
National Health Development Program (NHDP) to deliver a cost-effective package of basic health services. The eventual
sustainability of services is enhanced by emphasis on basic primary health centers with regional (equivalent to districts)
hospitals for referral services, appropriate training and use of mid-level health personnel, redeployment of existing
resources, provision of generic essential drugs, community participation and cost recovery, and strengthened
management support and supervision. NHDP’s integration of present vertical programs (e.g., immunizations, IEC,
AIDS, STDs, tuberculosis, leprosy), and the corresponding greater budget flexibility, will increase overall efficiency.
The program’s essential drug financing will contribute to the MOPH’s planned expansion of the Bamako Initiative, and
cost-recovery, particularly in hospitals, is incorporated in the NHDP. Beneficiaries and regional health teams have been
involved in the program’s design. Beneficiaries will participate in implementation, monitoring/evaluation and
adjustment of the NHDP, through participatory evaluations of program activities. Private contractors and consultants (under contracts with AGEOPPE) will execute the construction and rehabilitation of infrastructure. The private sector will also be involved in the social marketing of condoms and of mosquito nets. IDA financing of recurrent costs amounts to about US$2.8 million and represent less than 12% percent of the Program’s total recurrent expenditures. IDA funds are not being allocated for salaries of MOPH staff. The share of IDA in recurrent expenditures declines over the life of the Program as the government takes on an increasing share of financing of the Program. However, in spite of the government’s commitment to increasing levels of funding for the sector, foreseeable economic growth in Guinea-Bissau indicates that external support will be necessary to sustain health and other social services for some years after the end of the five-year National Health Development Program (NHDP) and the disbursement of the IDA credit.

21. Critical Risks (see fourth column of Annex 1-A):

<table>
<thead>
<tr>
<th>Project outputs to development objectives</th>
<th>Risk</th>
<th>Risk Minimization Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to improve the availability of health services, and increase their utilization.</td>
<td>medium</td>
<td>Careful definition of the minimum package of health care; and emphasis put on “operational” health centers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Project components to outputs</th>
<th>Risk</th>
<th>Risk Minimization Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weakness in management and technical capacity.</td>
<td>medium</td>
<td>Technical assistance and training.</td>
</tr>
<tr>
<td>Lack of donor coordination.</td>
<td>medium</td>
<td>Creation of the DCAE in DGPC, to be strengthened with the appointment of a Program Manager.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall project risk rating</th>
<th>Risk</th>
<th>Risk Minimization Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure of Government to live up to its commitment to sector reform.</td>
<td>medium</td>
<td>Thorough and constant monitoring of program implementation, with annual reviews. In the context of the CAS, this is one component of the policy dialogue that will determine the level of overall Bank support.</td>
</tr>
</tbody>
</table>

22. Possible Controversial Aspects:

The program faces a major risk of having its AIDS campaign and family planning promotion delayed because of cultural or religious standpoints on the use of contraceptives and condoms. To reduce that risk, the implementation of the program will be monitored very thoroughly, with involvement of the communities and annual reviews providing an opportunity for campaigning by the MOPH on these issues.

Block 4: Main Loan Conditions

23. Board and Effectiveness Conditions

All Board conditions have been met.

As conditions of credit effectiveness, the Government would:

(a) deposit into the project account the initial amount of US$73,00 equivalent. (Government counterpart funds for 1998).
(b) select the Program Manager and an expert in accounting and financial management with qualifications and experience satisfactory to IDA.

(c) establish a project management and computerized accounting systems acceptable to IDA.

(d) appoint an independent auditor acceptable to IDA.

(e) submit to IDA a signed contract with AGEOPPE for the management and execution of the construction and/or rehabilitation of health infrastructures.

(f) submit the final version of the NHDP Manual of Procedures, acceptable to IDA.

(g) submit the final version of the financial management manual to be used at Health Center level.

(h) submit a procurement plan for the first two project years.

(i) submit a detailed financing plan for 1998, showing the contribution of each donor, by item and by region.

24. Other [classify according to covenant types used in the Legal Agreements database.]

Execution of the Program (see also Section 4). The Government would:

(a) Adopt annual recurrent expenditures budgets and rolling two-year public investment program for health, acceptable to IDA; each year, the proportion of the recurrent budget dedicated to health should be at least 11%.

(b) Carry-out the program to ensure that the percent of health zones which are operational will be at least: 32% by December 31, 1998; 32% by December 31, 1999; 54% by December 31, 2000; 76% by December 31, 2001; and 83% by December 31, 2002.

(c) Carry-out the program to ensure that the percent of children under one year old fully immunized will be at least: 35% in 1998; 45% in 1999; 55% in 2000; 65% in 2001 and 75% in 2002.

(d) Carry-out the program to ensure that the percent of births safely attended by trained midwives will be at least: 30% in 1998; 35% in 1999; 40% in 2000; 45% in 2001; and 50% in 2002.

(e) Conduct with IDA and other donors comprehensive annual Program Implementation Reviews no later than November 30 of each year.

(f) Carry-out with IDA and other donors, no later than June 30, 2000, a midterm review in accordance with TORs and monitoring indicators acceptable to IDA.

Financial Covenants (see Section 4 and Annex 6 on Procurement and Disbursement arrangements).

Disbursements and Special Account (see Annex 6 on Procurement and Disbursement arrangements).

Procurement and Consultant's Services (see Annex 6 on Procurement and Disbursement arrangements).
Block 5: Compliance with Bank Policies

[ ] This project complies with all applicable Bank policies.

Task Manager: Tonia Marek
Country Director: Mahmood A. Ayub
## Annex 1A

### Project Design Summary

<table>
<thead>
<tr>
<th>Narrative Summary</th>
<th>Key Performance Indicators</th>
<th>Monitoring and Supervision</th>
<th>Critical Assumptions and Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAS Objective</strong></td>
<td></td>
<td></td>
<td>(CAS Objective to Bank Mission)</td>
</tr>
<tr>
<td>Poverty reduction through accelerating economic growth and shifting resources to rural areas and to human resource development.</td>
<td>- increased income of the poor</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Project Development Objectives</strong></td>
<td>(i) Reduction in mortality and morbidity due to:</td>
<td>To be obtained through specific surveys to collect data on the major causes of mortality and morbidity</td>
<td>(Development Objectives to CAS Objective):</td>
</tr>
<tr>
<td>To improve the health status and well-being of the population, particularly women and children.</td>
<td>• malaria; • diarrhea; • tuberculosis; • acute respiratory infections; • sexually transmitted diseases, including AIDS; • measles.</td>
<td>To improve the health status of the population in general, and would be consistent with the CAS objectives.</td>
<td></td>
</tr>
<tr>
<td>(ii) Reduction in perinatal mortality from 10% in 1997 to 3% in 2002. (iii) Reduction in total fertility rate from 6 to 5.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Project Outputs</strong></td>
<td>(a) Improved availability of health services.</td>
<td>(a) To be reviewed annually by donors and MOPH.</td>
<td>(Outputs to Development Objectives)</td>
</tr>
<tr>
<td>(a) Increase the number of operational health zones to provide minimum package of care, i.e. fully equipped and staffed (including at least one nurse and one midwife), and with an adequate supply of essential drugs, vaccines and contraceptives:</td>
<td>37 by 12/98 (32%) 37 by 12/99 (32%) 62 by 12/00 (54%)</td>
<td>The major causes of mortality and morbidity (malaria, high fertility, diarrhea, STDs, etc.) are well known. It is also known that the most important health event in Guinea Bissau is the management of some 50,000 pregnancies a year and the ante- and post-natal care that mother and babies require. If the health system</td>
<td></td>
</tr>
</tbody>
</table>

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1 Baseline and targeted values should be shown, with the latter divided into values expected at mid-term, end of project and full impact.
<table>
<thead>
<tr>
<th><strong>Project Components</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(a)</strong> Number of regions that are operational:</td>
</tr>
<tr>
<td>• 4 by 12/98</td>
</tr>
<tr>
<td>• 6 by 12/99</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>(b)</strong> Increased utilization of health services.</th>
<th><strong>(b-1)</strong> Increased consumer satisfaction with health care services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(b-2) Increased % of pregnant women receiving ante-natal care.</td>
<td></td>
</tr>
<tr>
<td>(b-3) Increased % of births safely attended by trained midwives from 30% in 1998, to 40% in 2000, and to 50% in 2002.</td>
<td></td>
</tr>
<tr>
<td>(b-4) Increased % of children under one year old fully immunized from 35% in 1998, to 55% in 2000, and to 75% in 2002.</td>
<td></td>
</tr>
<tr>
<td>(b-5) Increased % of patients successfully treated against malaria.</td>
<td></td>
</tr>
<tr>
<td>(b-6) Increased % of patients successfully treated against diarrhea.</td>
<td></td>
</tr>
<tr>
<td>(b-7) Increased % of patients successfully treated against STDs.</td>
<td></td>
</tr>
<tr>
<td>(b-8) Increased % of patients with complete TB treatment.</td>
<td></td>
</tr>
<tr>
<td>(b-9) Contraceptive prevalence rate from 5% in 1997 (in secondary cities) to 12% in 2002, from 1% in 1997 (in rural areas) to 10% in 2002.</td>
<td></td>
</tr>
</tbody>
</table>

| **(a)** through **(e)**: To be reviewed annually by donors and MOPH. |
| **(Components to Outputs)** |
| MOPH central level and regional health teams need |
| 1. Utilization and coverage of primary health care centers and referral centers. | - 8 by 12/00  
- 10 by 12/01  
- 11 by 12/02. |
| 2. Strengthening of institutional capacity at all levels. | (b) % of Government budget going to health: at least 11% each year. |
| 3. Management and development of human resources. | (c) % of MOPH budget going to primary health care:  
- from 25% in 1996 to 53% in 1998 and thereafter. |
| 4. Promotion of a better health. | (d) Development and establishment of an incentive system for health personnel. |
| | (e) Number of health centers management committees established and trained. |
| | (f) Number & % of health workers trained. |
| | (g) Number & % of midwives trained. |
| | (h) Regular payment of salaries and allowances:  
- 80% in 1998;  
- 90% in 1999;  
- 100% in 2000 and thereafter. |
| | (i) % of health centers with community financing actual revenues at least equal to 95% of estimates:  
- 15% in 1998;  
- 30% in 1999;  
- 45% in 2000;  
- 55% in 2001;  
- 70% in 2002. |
| | to have the managerial and technical capacity to implement the program. |
| | Sufficient and effective coordination is maintained by the various donors and Government. |
| | Adequate financing is made available by donors and Government to support program activities. |
| | (f) through (i): To be collected for the health information system (SIS). |
Sua Excelência
Senhor Mahmood AYUB
Director das Operações para Guinea-Bissau
Banco Mundial
Washington - E.U.A.

ASSUNTO: Carta de Política para o Desenvolvimento do Sector da Saúde

Senhor Director,


A política sectorial de saúde é parte integrante da política de desenvolvimento socio-económico global desejada pelo Governo da Guiné-Bissau. Entre os sectores sociais o Governo prioriza a Saúde. O referido programa visa reforçar o Sistema Nacional de Saúde, incluindo os serviços de prestação de cuidados, as estruturas de gestão e as ligações funcionais, intra e intersectorial, a todos os níveis, de forma a responder às necessidades gerais e específicas da população de cada região.

A política nacional de saúde baseia-se sobre os princípios dos Cuidados Primários de Saúde, através da implementação do Pacote Mínimo de Actividades: equidade, eficácia, eficiência, acessibilidade económica, participação comunitária e colaboração intersectorial.

As principais estratégias da nossa política sectorial de saúde são:

- Melhoramento e reforço da cobertura e qualidade dos serviços de cuidados primários e de referência;
- Reforço da capacidade institucional em todos os níveis;
- Reforço da gestão e melhoramento da qualidade dos Recursos Humanos;
- Promoção da saúde através de actividades intersectoriais e programas de Informação, Educação e Comunicação (IEC).
Estas estratégias visam uma articulação e uma complementaridade perfeita entre os níveis central, regional e local, com estruturas e instituições operacionais que respondam às necessidades da população em matéria de cuidados curativos, preventivos e promocionais.

Como o sector da saúde não pode sozinho garantir a saúde da população, o melhoramento dos indicadores socio-sanitários passará necessariamente pela abordagem intersectorial que envolva vários parceiros e sectores, como o aprovisionamento em água potável, a educação e a informação, a construção de vias de acesso, a protecção do ambiente e saneamento, a promoção e alfabetização das mulheres, a agricultura, as condições de habitação, o desenvolvimento e a descentralização do nível administrativo, a criação de emprego sobretudo para os jovens, a urbanização, etc.

Para lidar ao mesmo tempo com as limitações orçamentais do Estado e a incerteza quanto à ajuda externa, vamos pautar por uma eficiência na utilização dos recursos pela recuperação dos custos tanto a nível dos Centros de Saúde como nos hospitais, e pelas formas de reforço financeiro aos programas sanitários. O PNDS é um instrumento de grande utilidade para este objectivo, pois irá permitir orientar e priorizar a afectação de recursos, servindo de suporte ao controle e à avaliação a todos os níveis.

É neste contexto que o PNDS 1998 - 2002 aparece como um marco importante para o reforço do sistema de saúde, numa base que se ajude às reais necessidades sociais e condições económicas e faça parte integrante das estratégias globais de desenvolvimento do país. Trata-se de uma abordagem global do conjunto do sistema sanitário baseada numa análise da situação e identificação das necessidades prioritárias numa situação de recursos limitados.

São objectivos do Plano Nacional de Desenvolvimento Sanitário:

- Definir as grandes prioridades e estratégias nacionais em matéria de desenvolvimento sanitário para o período de 1998 - 2002, respondendo às prioridades fixadas;

- Responder equitativamente e com eficiência aos problemas e às necessidades de todas as regiões;

- Acelerar a descentralização do sistema nacional de saúde;

- Dispor de um quadro de intervenção coerente para a coordenação das acções tanto a nível nacional como com os parceiros de desenvolvimento.

Para desenvolver todo este processo, organizaram-se muitos encontros e discussões. A elaboração do PNDS foi feita com o apoio de técnicos nacionais, a participação activa de todas as regiões e a assistência técnica e financeira de vários organismos e agências internacionais, bem como de outros sectores.
As principais etapas que marcaram este processo participativo de baixo para cima, são:

- Seminário sobre a Reorganização do Sistema Nacional de Saúde, em Abril de 1994;
- Elaboração do guia de planificação regional, em Março de 1995;
- Seminário sobre o financiamento do sistema de saúde, em 1995;
- Elaboração do perfil sanitário para as equipas regionais de saúde, com o apoio do nível central, em Novembro e Dezembro de 1995;
- Reunião sobre o desenvolvimento e a valorização dos recursos humanos, em Janeiro e Fevereiro de 1996;
- Atelier sobre a coordenação e gestão da ajuda externa destinada ao sector da saúde, em Fevereiro de 1996;
- Encontro sobre a análise do sector da saúde: definição de prioridades e estratégias nacionais, em Março de 1996;
- Reunião sobre a situação sanitária e desenvolvimento do sistema de saúde do Sector Autónomo de Bissau, em Junho de 1996;
- Seminário sobre programas regionais e nacionais prioritários, em Junho de 1996;
- Reunião intersectorial, em Janeiro de 1997;
- Realização da Mesa Redonda sectorial da saúde, em Junho de 1997.

É a partir do conjunto de perspectivas que o PNDS espera estabelecer nos próximos cinco anos uma nova parceria com as Agências doadores e Organismos Internacionais para que as suas contribuições técnicas e financeiras encontrem um quadro propício à satisfação dos seus interesses mútuos e dos da promoção de uma melhor saúde para as populações da Guiné-Bissau.

Dr. B. Gomes Co

cc: - Senhor Primeiro Ministro
- Senhor Ministro dos Negócios Estrangeiros e Cooperação
- Senhor Ministro da Economia e Finanças
Annex 2

Detailed Program Description

A yearly description of activities to be financed by the Government, IDA and other donors will be agreed upon before mid-December of the previous year. Such a yearly plan will describe all activities, their cost, their source of financing. The present program description is provided to give the framework within which the financing of the yearly plan can be made.

Program Component I - Utilization and coverage of Primary Health Care Centers and Referral Centers - US$37.5 million (total cost of component).

The objective of this component is to ensure that health services, at the level of primary health care centers as well as at the level of referral centers, provide good quality, comprehensive, continuous and integrated health care accessible to all. In this domain, the program aims to provide a basic minimum package of cost-effective integrated preventive and curative health services in health centers accessible to a majority of the population, with community outreach and with effective support and supervision by regional health (equivalent to health district) teams. Central support and supervision, now provided through national programs (e.g., AIDS, EPI, MCH, FP, etc.), will be coordinated at the national level and integrated at the regional and peripheral levels. The emphasis will be on system and service integration and decentralization, and on rural and marginal urban areas.

The strategy involves: (i) a definition of health areas, consisting of a comprehensive network of health centers, health posts and outreach activities to ensure access for all; (ii) partial cost-recovery with receipts managed by local committees; and (iii) the use of hospitals mainly as referral centers.

Indicators are described in Annex 1-A (section on program output).

I.1 - Ensure adequate physical coverage of health facilities accessible to a majority of the population

Description.

The DGSP has developed norms for infrastructures, personnel, medical equipment and furniture, transport and communication equipment, as well as for maintenance. It has also defined the distribution of health infrastructures (*carta sanitaria*) taking into account the distribution of population and the characteristics of the different regions. The map of health centers will be kept under constant review and revised as necessary. Those norms and map, as well as some preliminary estimates made for the hospitals, have provided the basis for identifying the health facilities to be constructed or rehabilitated, and/or equipped and furnished. This sub-component includes:

- Rehabilitation of health centers, in accordance with the map of health infrastructures (*carta sanitaria*);
- Construction of five new health centers in the city of Bissau, to relieve the pressure on the national hospital to provide primary health care (to be selected from the following list of sites: Ga Bafata (CSC); Pefine (CSC); St Luzia (CSC); Luanda (CSC); Antula (CSB); Cantum (CSB); Bairro Militar (CSB); Plaque (CSB); Missira (CSC); Kélélé extension (CSC).
- Equiping and furnishing health centers;
• Construction of the Mansoa Regional Hospital and rehabilitation of the other regional hospitals and of the Simao Mendes National Hospital, and their equipment.

In order to improve the advanced strategy (or community outreach) necessary to ensure adequate coverage, the program also includes support to communities for the supervision, training, drug and contraceptive supply for the operation of village health units (Unidades de Saúde de Base - USB).

The IDA credit will finance, during the first two years, new constructions, equipment and furniture of facilities in the regions of Bissau, Cacheu and Bafata, including health centers (type C and B) and related facilities (water supply, staff houses, offices, etc), regional health offices and warehouses for storage and distribution of drugs; and related services: preparation of specifications for equipment and civil works management to be carried out by AGEOPPE.

Government and other donors including AfDB will finance almost the same kind of expenditures for other regions not covered so far. The French FAC will finance the construction and equipment of a regional hospital in Mansoa.

Implementation arrangements. In order to reduce the workload of the DAF in the DGPC (normally responsible for procurement) and the need for additional staff and consultants, the implementation of all civil works (construction and rehabilitation) financed by the IDA credit (and also by any other donors interested in such arrangements) will be delegated by MOPH to AGEOPPE, which will in turn sub-contract to consultants for the preparation of detailed design and bidding documents and to contractors for the execution of the works. The DCPS in the DGSP, the regions for the health centers, and the DSH in the DGSP will be responsible for the overall planning of the works, the availability of land (if required), the preparation of the technical specifications and any other information needed by AGEOPPE to prepare the detailed design and bidding documents. The submission by MOPH to AGEOPPE of a signed agreement containing all that information for the first year of the program will be a condition of effectiveness of the IDA credit, and each year a new dossier will be submitted at the annual review.

I.2 - Ensure the availability of a minimum package of care

Description.

• At the level of the health centers, provision of a minimum package of cost-effective integrated preventive and curative basic health services. Central support and supervision, now provided through national programs, will be coordinated at the national level and integrated at the regional and peripheral levels (FP, EPI, Nutrition will be integrated into MCH on the one hand, and malaria, tuberculosis, leprosy, STD/AIDS, oncho, will be integrated into disease control activities on the other hand). The minimum package of care will include: pre- and post-natal care including family planning, assisted deliveries, curative care, provision of drugs, contraceptives and vaccines, basic laboratory services, basic management of the health centers, and the execution of regular outreach activities.

• At the level of the regional hospitals functioning mainly as referral centers, provision of secondary care. The minimum package of care at this level will include: minor surgery, complicated deliveries, general anesthesia, a definite set of laboratory services, availability of about 150 drugs, echography.

• Provision of care by the Simao Mendes National Hospital as the secondary reference center for the health centers in the capital and as the tertiary reference for the rest of the country.
In order for those minimum packages of care to be of an adequate quality and to be delivered, the program includes measures and actions to ensure the availability of qualified personnel (see Component III) and essential drugs; support for the development, establishment and operation of a system for regular and integrated supervision of the regions (equivalent to a district) by a national multidisciplinary team with the provision of adequate resources for supervisors; the introduction of a simple system of health statistics; the development and operation of a reference system (cards, monitoring) and feedback; the installation and operation of a blood safety system; the reduction of vertical programs; the introduction of a cost-recovery system to ensure a regular supply of essential drugs and other materials as well as to permit the introduction of some incentives for health personnel; and the operation of other national services (National Laboratory, Mental Hospital, Tuberculosis and Leprosy Hospitals, etc.).

Regarding essential drugs, the program includes measures to reactivate the National Committee on Drugs (Comissão Nacional de Medicamentos) and to revise periodically the list of essential drugs on the basis of updated treatment manuals; the promotion of a rational use of essential drugs by health personnel with standard treatment schemes; the construction or rehabilitation of the central and regional drug depots and of the pharmacies of health facilities and their equipment; the adoption of a new legal status for the central and regional depots to make them semi-autonomous and to enable them in particular to buy and sell drugs; and the introduction and operation of a comprehensive system for the purchase, storage, transport and distribution of essential drugs, including the setting-up of prices and cost-recovery.

With respect to hospitals, the program includes the reactivation of the Directorate of Hospital Services (Direcção dos Servicos Hospitalares - DSH) to coordinate the hospital policy; the definition of the functions, norms and technical requirements, and the consequent allocation of personnel and other resources, for the different referral levels; the adoption of a new legal status including in particular financial autonomy; the transfer of the activities of the August Third Hospital to the Simao Mendes National Hospital (Hospital Nacional Simão Mendes - HNSM) as the only referral hospital at the national level; and a whole set of measures and activities for the management and operation of hospitals, including the development and implementation of a management system, the recruitment/reassignment and training of personnel, the operation of a hospital statistics system and the introduction of cost-recovery. Some of these activities will require hiring specialized technical assistance.

The IDA credit will finance, during the first two year of the program, the procurement of the totality of the essential drugs and contraceptive initial stock, to ensure an efficient start up of the system, and part of the yearly stock replenishment of drugs and contraceptives; as well as the services of short term consultants needed for establishing lists, specifications standardized treatment and documentation for the procurement of drugs.

Government and the AfDB will finance the reagents and materials.

Implementation arrangements. The DCPS in DGSP, in collaboration with the regions and other directorates and services, will be responsible for ensuring that the minimum package of health care is introduced at the level of the primary health care centers; the DSH in DGSP and the hospitals themselves will be responsible for ensuring that the minimum package of care is introduced at the hospitals. The DSF in DGSP, together with the regions and the DCM and DRM, will be responsible for essential drugs.

Program component II - Strengthening of Institutional Capacity at all levels (central, regional and local) - US$12.8 million (total cost of component).

The objective of this component is to improve the organization and management capacity at all levels of the health system, and to ensure that the management of financial and other resources be more efficient, more equitable and more transparent. In this domain, the program aims at improving the legal framework within which the health system
operates, planning, administrative and financial management, the coordination and management of external assistance, community management and financing, and private sector participation.

In order for the NHDP to be properly managed and implemented, the strategy involves capacity building at all levels, including the strengthening of consultation and coordination mechanisms within MOPH and between MOPH and the Ministry of Finance (MOP), the reinforcement of the national system of health statistics, the integration of vertical programs, the development of management capacity in the regions and the decentralization of financial and budgetary functions, the collaboration between the public and the private sector, and the management of cost-recovery (particularly for drugs) with community committees. The organigram of the MOPH was revised in order to allow for the creation of the Technical Committee (Conselho Técnico) in DGSP, the NHDP Management Committee (Comité de Gestão) bringing together the DGCP and the DGSP, the DSH, the DIECS, the DIE, and the DCAE, as well as the integration of vertical programs at the central level in either SF or GE.

Indicators will be:

- The availability of comprehensive and well designed national and regional plans.

- Ratios between outputs and inputs: for example, number of visits per health worker, immunization cost per child, utilization of hospital services (number of admissions), etc.

- Availability of the most utilized essential drugs, in the central depot, in the regional depots and in the health facilities.

- Number of health centers management committees established and in operation, compared to the total number of health centers.

- Community financing: actual receipts versus estimated receipts.

- Percentage of recurrent expenditures covered by community financing.

- Percentages of the cost of essential drugs covered by community financing (at the levels of the national and the regional drugs depots, and of the health facilities).

- Distribution of total external assistance and Government financing, by region, per inhabitant and per type of activity.

II.1 - Planning of activities at all levels

Description.

- In order for planning to be more consistent, efficient and coordinated, the program includes the development of processes, procedures, forms and timetables for the planning cycle, as well as the establishment and operation of the Management Committee. It also includes the reorganization and strengthening of the health information system with the creation of the Serviço de informação e Estatística (SIE) in the Direcção de Planificação (DP) in order to improve MOPH’s planning, decision making and monitoring capacities. In collaboration with Epidemiology (Epidemiologia), the system will collect health statistics routinely every month in each health facility, but also some data that can be obtained through specific surveys and on the occasion of supervision visits. It will integrate various databanks that are useful for planning, including health statistics, information and data on finances and budgets, programs and projects in the health sector and foreign assistance, existing assets (buildings, equipment and vehicles) and human resources.

The IDA credit will finance, for the first two years of the program, operating costs for the supervision of planning and training activities, including subsistence allocations and ancillary expenses (fuel, vehicles operation and maintenance) related to travels to be undertaken by the supervisory teams to and within the regions.
Government and other donors will finance the technical assistance for a Public Health specialist and for a Health Economist to strengthen the DGPC.

Implementation arrangements.

The DGPC, and more particularly the DP and SIE, will be mainly responsible for implementation. The DP will be strengthened with technical assistance, for a period of at least two years, by a public health specialist and a health economist.

II.2 - Administrative and Financial Management

Description.

In order for the administrative and financial management to be more transparent, rational and efficient, the program includes the development and introduction of standard procedures and instruments for administrative and financial management at all levels; the appointment and training of professional managers for the regions; the training in financial management and supervision of personnel at all levels (including regional managers and members of the management committees of the health centers); and the establishment of an information system on financial flows to permit the monitoring of the execution of the program and budget, including counterpart funds, external assistance and community financing.

The IDA credit will finance, for the first two years, the technical assistance for the accounting and financial management, for the Program Manager; and office equipment, furniture needed to accommodate the technical assistance; parts of the costs incurred for the program operation and coordination; the cost of the yearly audits of the program financial statements, with special emphasis on the management of IDA credit and special account.

Government and other donors will finance some of the operating costs as well as some technical assistance.

Implementation arrangements. The Direcção de Administração e Finanças (DAF) in DGPC will be primarily responsible for implementation. The DAF will be strengthened with technical assistance by an expert in accounting and financial management.

II.3 - Coordination of external assistance

Description.

In order to ensure a better management and coordination of external assistance for the health sector, the program includes the activation and strengthening of the Direcção de Cooperação da Ajuda Externa (DCAE) in DGPC, with the establishment and operation of a data bank on external assistance. In addition to maintaining a system for the financial monitoring of NHDP's implementation, the DCAE will assist the Director General of DGPC in the preparation of requests for external funding; participate in the organization of round tables for the health sector; follow-up on consultative groups and relevant donor consultation decisions; analyze aid modalities and trends and prepare strategies for donor negotiations; and assure link between planning activities and aid coordination.

The IDA credit will finance, for the first two years, the technical assistance to be provided by the Program manager and an accountant along with, office equipment and furniture needed to accommodate the
technical assistance, and part of the costs incurred for the program operation and coordination (already included in II.2 above).

**Government and other donors will finance the short-term technical assistance to DCAE needed to establish, and train MOPH personnel in operating the data bank on external assistance.**

**Implementation arrangements.** The DCAE in DGPC will be mainly responsible for implementation.

**II.4 - Community Management and Financing**

**Description.**

In order for community management and financing to be introduced in the whole country and to improve its organization and the framework within which it operates, the program includes the definition of the modalities, procedures and institutional arrangements for management committees at the level of the health centers and of the hospitals; the progressive expansion of the Bamako Initiative with the establishment, training and supervision of management committees and arrangements for the preparation of annual plans by the health centers and the hospitals; and the promotion of other forms of community participation through IEC, and to intersectoral initiatives at different levels, and collaboration with the private sector and NGOs.

The IDA credit will finance operating costs, for the supervision of management advisory and training activities, which include subsistence allocations and ancillary expenses (fuel, vehicles operation and maintenance) related to travels to be undertaken by the advisory and training teams to and within the regions.

**Government and other donors will finance technical assistance to help set up and monitor the Bamako Initiative as well as training expenditures.**

**Implementation arrangements.** In collaboration with the regions, the DCPS in DGSP will be primarily responsible for implementation with respect to the health centers, and the DSH in DGSP will be primarily responsible for implementation with respect to hospitals.

**II.5 - Assets Management**

**Description.**

To improve the management of MOPH's assets (buildings, vehicles, etc.) and their maintenance, the program includes the development and establishment of an assets register and of a monitoring system at all levels; the development and implementation of a program of preventive maintenance for equipment and vehicles; measures to standardize equipment and vehicles in order to facilitate operations, maintenance and repairs; and the training of personnel in those fields.

The IDA credit will finance parts of the short-term local and foreign consultancies to assist in defining, planning and implementation of an asset management including measures to improve monitoring and maintenance of equipment and vehicles.

**Government and other donors will finance parts of the same items.**

**Implementation arrangements.** The DAF (Directorate of Financial Affairs) in DGPC will be primarily responsible for implementation (with the assistance of long- and short-term consultants).
II.6 - Legal Framework for the Health Sector and Private Sector Participation

Description.

The program includes the preparation or revision of the different legal texts covering the organization and the functioning of the sector; and measures to ensure the operation of the Inspection General (Inspeção Geral). In order to allow the private sector to complement the public sector in the provision of health care at all levels, the program also includes the preparation and adoption of a legal and regulatory framework for private sector participation; the introduction of a system of registry, authorization, monitoring and inspection for the provision of services; and the preparation of standards agreements for the delegation to the private sector of public health activities.

The IDA credit will finance short-term local and foreign -- if necessary -- consultancy, in the fields of administration and law, to assist in the improvement of the legal framework and drafting of texts proposals when required.

Government and other donors will finance provision of services by the private sector, in particular for the social marketing of condoms and of mosquito nets.

Implementation arrangements. The DGSP and the DGPC, in collaboration with the Ministry Cabinet and the Inspection General, will be responsible for implementation.

Program Component III - Management and Development of Human Resources - US$12.6 million (total cost of component).

The objective of this component is to improve the quality, efficiency and distribution of human resources through the implementation of specific strategies for personnel management and training. In this domain, the program aims at improving (i) the management of human resources at both the central and regional levels, (ii) the motivation, working conditions and career prospects of health personnel, and (iii) the training (for technical aspects as well as for management) of health personnel in accordance with the needs and priorities of the health system.

The strategy is based on the fact that, in order to function properly, the health system needs an appropriate number (with the right expertise mix) of well-trained and decently paid health workers, with an adequate system of supervision. A human resources development plan has been prepared which defines the norms, the qualifications and experience required, the number of positions needed, the training plan (basic and in-service training, continuing education and post-graduate education, in-country and out of the country), and concrete incentives to ensure an equitable distribution of personnel between regions and between rural and urban areas.

Indicators will include:

- Timeliness of payment of salaries and allowances to health personnel.
- Actual number of health personnel, as compared to the norms: per region, per health area, etc.
- Actual number of supervision visits, compared to the plan.
- Number of health personnel trained (particularly midwives, or traditional birth attendants).
- Availability of a human resources data bank.
III.1 - Management of Human Resources

*Description.*

In order to improve the management of human resources at both the central and regional levels, the program includes:

- The improvement and operation of a decentralized information system for the management of human resources (*Sistema de Informação e Gestão de Recursos Humanos da Saúde - SIGRHS*) with the establishment of norms and processes and the training of staff in the regions.

- The implementation of norms and criteria for the recruitment, assignment, distribution and mobilization of personnel; the payment of allowances; disciplinary measures; and procedures and processes for training at all levels.

- The establishment of norms for the number and types of positions in the different services and health facilities, the monitoring of the situation, and the regular review at the level of the Management Committee in DGPC of personnel planning on a short-, medium- and long-term basis.

- The development of coordination mechanisms within MOPH and with other relevant ministries for the development of human resources (Civil Service, Finances, Education, etc.).

The IDA credit will finance local and foreign short-term consultancies to assist in improving the human resources management system.

*Government and other donors will finance two years of long-term technical assistance.*

*Implementation arrangements.* The DRH in DGPC, in collaboration with the regions, will be responsible for implementation.

III.2 - Improvement of the motivation, working conditions and career prospects of health personnel

*Description.*

The program includes:

- Development and establishment of an incentive system based on the degree of isolation (for posting outside of Bissau), improvement of the criteria for the payment of allowances (*subsidios de risco e de vela*), and review of the procedures for the payment of salaries.

- Establishment and implementation of a system of fellowships for training in accordance with the priorities established by the program.

- Review and implementation of a health career system, in accordance with the definitions of the civil service.

- Construction or rehabilitation of 195 lodgings for health personnel in the regions (in areas outside of the capital).

- Possibility of using part of the receipts of the cost-recovery system to pay bonuses to health personnel.
The IDA credit will finance part of the investment needed to improve working and living conditions of staff, including provision of lodging and safe water in the regions; and foreign and local consultancy services to assist in the design and establishment of incentive and development career systems.

**Government and other donors will finance the same but in different regions.**

**Implementation arrangements.** The DRH in DGPC will be primarily responsible for implementation with regard to the services and regulatory aspects, while the construction or rehabilitation components will be delegated to AGEOPPE.

**III.3 - Training of Personnel**

**Description.**

- In order to improve the training of personnel, both on technical matters and on management, in accordance with the needs and priorities of the health system, the program includes:

  - The establishment of the National Medical School (*Escola Nacional de Saúde - ENS*), integrating training activities at present carried out by ESM, ETQS, and PSS.
  
  - The development and implementation of training activities, in accordance with the priorities of the program, in order to: (i) complete the staffing of primary health care facilities with nurses and midwives; (ii) fill the vacancies for technicians that will occur during the 5-year period; (iii) improve the qualifications of technicians; and (iv) adapt the curricula of nurses and midwives and the pedagogical methods to the new definitions of the health system (i.e. minimum package of health care), to the health problems the most frequently encountered and to the established priorities within the NHDP.
  
  - The completion of the training of doctors at present enrolled in ESM.
  
  - The development of programs of continuing education linked to supervision.
  
  - The preparation of training modules to assist the regions in their programs of continuing education.
  
  - The development and reinforcement of training programs in management, administration and accounting for the personnel of the regions, the management committees of health centers, the technical personnel of health facilities and the staff of hospitals.
  
  - The development and the monitoring of implementation of a medium- and long-term plan for post-graduate training both inside and outside of the country.

  The IDA credit will finance, the second phase of the post-graduate training of medical doctors with a foreign training institution, local and foreign training specialists for short term consultancies, and operating costs, for the supervision of training activities.

  **Government and other donors will finance per diem for trainees, equipment and technical assistance for the ENS.**

**Implementation arrangements.** The DRH in DGPC, in collaboration with DGSP and the regions, will be responsible for implementation, with the exception of the establishment of the National Medical School (*Escola Nacional de Saúde - ENS*) which is the responsibility of the Minister of MOPH.
Program Component IV - Promotion of a Better Health - US$3.2 million (total cost of component).

The objective of this component is to promote a better health for the population through intersectoral activities, including those related to a better hygiene, birth spacing and STDs/AIDS prevention. In this domain, the Program aims at strengthening intersectoral coordination for the carrying-out of health-related activities, especially IEC. The activities will involve the private sector, NGOs and communities, and will be selected for their expected cost-effectiveness in Guinea-Bissau.

The approach is to develop and implement a strategy to influence the attitudes and practices of the population in general in a direction favorable to health, through operational research, pilot projects, and interpersonal and mass media communication. It will also involve collaboration with other ministries and organizations for water supply, the education of youth (particularly girls), the functioning of the health centers management committees, etc.

- Indicators will include: indicators of KAP (Knowledge, Attitudes and Practices) in priority areas (AIDS, nutrition, population, for example).

Description.

In order to be able to influence positively the behavior of the population, the program includes the formulation of a national IEC strategy; KAP surveys and operational research on behavior of the population in cases of diseases and pregnancies (“health seeking behavior”) in collaboration with other sectors and NGOs; and the establishment and operational use of a databank on the attitudes, practices and behavior of the different ethnic groups that influence their health status or their behavior when sick. It also includes specific IEC activities: production and testing of IEC materials to be used at different levels; improvement of the technical qualifications of DIECS personnel; promotion of mass media and other campaigns; training of health personnel in interpersonal communication to deal with concrete situations (nutritional orientations, continuity of treatment for tuberculosis, importance of immunizations, how to avoid dehydration in the case of diarrhea, risks of DSTs and AIDS); and coordination of the various IEC programs at the central level and in the regions. Finally, the program includes the establishment or activation of coordination mechanisms with other sectors (Ministries and public entities, but also private sector and NGOs) which are particularly important and relevant for the health status of the population; the dynamisation of the Interministerial Committee against AIDS; and the social marketing of condoms and mosquito nets, creating a private capacity to continue this effort in the future.

The IDA credit will finance short term local and foreign consultants specialized in IEC, KAP surveys, studies and the continuation of the condom social marketing program.

Government and other donors will finance long-term technical assistance needed as well as investment costs in equipment and vehicles.

Implementation arrangements. The DIECS will be primarily responsible for implementation.
Annex 3

Estimated Program Costs

<table>
<thead>
<tr>
<th>Program Component</th>
<th>Local</th>
<th>Foreign</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilization and Coverage</td>
<td>25.3</td>
<td>12.2</td>
<td>37.5</td>
</tr>
<tr>
<td>Strengthening Institutional Capacity</td>
<td>6.1</td>
<td>6.7</td>
<td>12.8</td>
</tr>
<tr>
<td>Management/Development Human Resources</td>
<td>6.0</td>
<td>6.6</td>
<td>12.6</td>
</tr>
<tr>
<td>Promotion of Better Health</td>
<td>1.5</td>
<td>1.7</td>
<td>3.2</td>
</tr>
<tr>
<td><strong>Total Program Cost</strong></td>
<td><strong>39.0</strong></td>
<td><strong>27.1</strong></td>
<td><strong>66.1</strong></td>
</tr>
</tbody>
</table>
Economic Analysis

I. Cost-effectiveness/best practice analysis

This analysis is based on the part of the NDHP budget concerned with the District level minimum package of activities only (which represents about half of the whole NHDP budget). It shows that the NHDP budget is within acceptable norms.

<table>
<thead>
<tr>
<th>Year</th>
<th>Functionality rate</th>
<th>Cum. increase in functionality rate (%)</th>
<th>Rec. Costs</th>
<th>Inv. Costs</th>
<th>Total Costs</th>
<th>Cum. increase in growth rate of total costs (%)</th>
<th>Population (# of people)</th>
<th>Total costs per inhabitant</th>
<th>Cum. increase in rate of total cost per inhabitant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>0.55</td>
<td>9.09</td>
<td>2,645,404</td>
<td>1,795,279</td>
<td>4,440,683</td>
<td>5.11</td>
<td>1,088,000</td>
<td>4.08</td>
<td>2.93</td>
</tr>
<tr>
<td>1999</td>
<td>0.60</td>
<td>9.92</td>
<td>2,818,369</td>
<td>1,849,138</td>
<td>4,667,507</td>
<td>5.37</td>
<td>1,111,000</td>
<td>4.20</td>
<td>3.02</td>
</tr>
<tr>
<td>2000</td>
<td>0.65</td>
<td>10.74</td>
<td>3,003,485</td>
<td>1,904,612</td>
<td>4,908,097</td>
<td>5.65</td>
<td>1,134,000</td>
<td>4.33</td>
<td>3.11</td>
</tr>
<tr>
<td>2001</td>
<td>0.70</td>
<td>11.57</td>
<td>3,201,597</td>
<td>1,961,750</td>
<td>5,163,347</td>
<td>5.94</td>
<td>1,157,000</td>
<td>4.46</td>
<td>3.21</td>
</tr>
<tr>
<td>2002</td>
<td>0.75</td>
<td>12.40</td>
<td>3,413,609</td>
<td>2,020,603</td>
<td>5,434,212</td>
<td>6.25</td>
<td>1,180,000</td>
<td>4.61</td>
<td>3.31</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>15,082,465</td>
<td>9,531,382</td>
<td>24,613,846</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Series 1 = Cumulative increase in functionality rate
Series 2 = Cumulative increase in growth rate of total costs
Series 3 = Cumulative increase in growth rate in total cost per inhabitant.

This analysis is based on a NHDP budget of US$60.1 million instead of US$66.1 million. The economic analysis is largely unaffected by the additional $6 million because it will be used for investment costs at the central and regional levels (US$3.7 million for the social marketing of condoms and US$2.3 million for national and regional hospital rehabilitation). The country is still well below the subsaharan average in terms of the standard recommended minimum package cost/inhabitant.
Main assumptions:
Estimates are based on the following assumptions:
- The utilization rate of health services increases by 50% (from 50% of optimal functionality in 1998 to 75% in 2002);
- Salaries and cost of life increases with 3% per year;
- The population growth rate is 2.1% per year.

As can be seen from the above table and graph, the cost per inhabitant will increase slowly from around US$4 to US$4.6 over the NHDP period, although an increase in effectiveness is expected to be achieved. The cost per unit of activity (measured by the number of new cases treated in the District) is expected to decrease from around US$14.5 (frequency rate of 0.275 new cases/inhabitant/year) to around US$11.8 (frequency rate of 0.375 new cases/inhabitant/year).

In case of a theoretical “good” utilization rate of services (0.5 new cases/inhabitant/year, which is a long term objective), compared to the norm which the Bank uses in “Better Health in Africa” -BHA- the NHDP costs for primary care services to be provided seem to be within acceptable levels. The NHDP points to a cost of US$4.49/person/year which compares favorably to US$8.15/person/year for BHA. Most of the difference is due to the relatively low salaries in Guinea-Bissau. The average civil service wage in Guinea-Bissau is about one sixth of the UEMOA average. For comparison purposes, if the salary component of the NHDP is multiplied by 6, the NHDP cost/person/year would reach US$6.75, much closer to the BHA norm.

II. Analysis of financial and economic impact

In 1996, the Government budget for health was equivalent to US$2.26 million. For 1997, the budget proposed by Government for the Health Sector is US$2.53 million (at the rate of 580 FCFA/dollar), which includes the E.U. budgetary aid (the E.U. aid is expected to remain constant in the coming years at around US$1.25 million/year). Thus, it is expected that throughout the NHDP period, Government budget available for the health sector will remain at around US$2.5 millions per year. In the NHDP budget (next page), it is estimated that the recurrent costs to be born by the Government (plus structural adjustment aid from the E.U.) will amount to US$10.4 for the five years of the NHDP, or about US$2 million/year. To this, about US$400,000/year is added in investments (from the E.U. budget). Thus, the NHDP is well within the limits of what will be available in terms of government budget.

The communities will also contribute to recurrent costs through the implementation of a cost-recovery system for drugs, its contribution will only represent 2% of the overall NHDP budget for year 1, but it will increase steadily as the Bamako Initiative and the hospital cost-recovery systems expand.

The NHDP will be financed as follows:
III. Analysis of budget allocation according to NHDP objectives

The table below shows that out of the total NHDP budget (US$60 millions), 59% are to increase coverage, 21% for human resources development, 18% for institutional strengthening and 2% for IEC. If the same budget is analyzed, without taking into account the technical assistance (which represents 23% of the total budget), we have 66% for coverage, 23% for human resource development, 9% for institutional strengthening, 2% for IEC. Technical assistance decreases yearly throughout the NHDP as knowledge is transferred to nationals and as more nationals are being trained to take over.
IV. Analysis of budget allocation according to cost center

More than 53% of the budget will be targeted to the districts (Minimum Package of Activities - PMA -). The national hospital, Simao Mendez, represents only 14% of the total budget. These allocations do reflect the priorities set in the NHDP.

<table>
<thead>
<tr>
<th>Cost center</th>
<th>TOTAL</th>
<th>T.A.</th>
<th>TOTAL without T.A.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Districts (PMA)</td>
<td>53%</td>
<td>33%</td>
<td>57%</td>
</tr>
<tr>
<td>Central Hospitals and Health School, Programs, Central</td>
<td>24%</td>
<td>19%</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>23%</td>
<td>47%</td>
<td>17%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: Hôpital National Simão Mendez 14% 17% 13%

V. Analysis of the coherence between recurrent and investment costs

The NHDP’s budget combines recurrent and investment costs in a consistent manner (which was not the case before the NHDP, as recurrent costs were established by the MOPH, while investment budgets were decided by the Ministry of Plan, without always coordination among ministries).

Fifty-seven percent of the NHDP budget is for investments and 43% for recurrent costs. The main reason for a rather high percentage for investments is that due to the need for qualified human resources for the implementation of the NHDP, 23% of the total budget is to buy technical assistance (but on a rapidly decreasing basis as can be seen in the table below), which represents 40% of the investment budget.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal</td>
<td>1 211 956</td>
<td>1 233 991</td>
<td>1 256 467</td>
<td>1 279 392</td>
<td>1 302 775</td>
</tr>
<tr>
<td>Drugs</td>
<td>2 016 551</td>
<td>2 146 388</td>
<td>2 282 299</td>
<td>2 335 295</td>
<td>2 481 580</td>
</tr>
<tr>
<td>Maintenance</td>
<td>410 863</td>
<td>461 467</td>
<td>507 945</td>
<td>518 104</td>
<td>528 466</td>
</tr>
<tr>
<td>Other</td>
<td>1 174 415</td>
<td>1 197 903</td>
<td>1 221 861</td>
<td>1 246 298</td>
<td>1 271 225</td>
</tr>
<tr>
<td>Recurrent</td>
<td>4 813 785</td>
<td>5 039 749</td>
<td>5 268 572</td>
<td>5 379 089</td>
<td>5 584 046</td>
</tr>
<tr>
<td>Constructions</td>
<td>1 128 889</td>
<td>4 738 124</td>
<td>3 658 391</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>1 719 832</td>
<td>2 417 260</td>
<td>4 267 138</td>
<td>1 775 624</td>
<td>1 205 791</td>
</tr>
<tr>
<td>Tech. Assist.</td>
<td>3 174 424</td>
<td>3 349 013</td>
<td>3 221 114</td>
<td>2 262 145</td>
<td>1 130 929</td>
</tr>
<tr>
<td>Investments</td>
<td>6 023 145</td>
<td>10 504 937</td>
<td>11 146 643</td>
<td>4 037 769</td>
<td>2 336 720</td>
</tr>
<tr>
<td>Total</td>
<td>10 836 930</td>
<td>15 544 686</td>
<td>16 415 215</td>
<td>9 416 858</td>
<td>7 920 766</td>
</tr>
</tbody>
</table>
### NHDP BUDGET (1998-2002) in USS

<table>
<thead>
<tr>
<th>Code compt.</th>
<th>Code PND5 : RESUME</th>
<th>PND5 TOTAL (US$)</th>
<th>%</th>
<th>Financements Assurés</th>
<th>Besoin net de financement</th>
<th>Pour mémoire: part de la population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rubriques de dépenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.0.0</td>
<td><strong>CUSTOS DE FUNÇÂOAMENTO</strong></td>
<td>26 085 240</td>
<td>43%</td>
<td>23 043 539</td>
<td>3 041 701</td>
<td>4 471 292</td>
</tr>
<tr>
<td>1.1.0</td>
<td>Custos referentes ao pessoal</td>
<td>6 284 580</td>
<td>10%</td>
<td>6 284 580</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.1.1</td>
<td>Salários</td>
<td>4 921 558</td>
<td>8%</td>
<td>4 921 558</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.1.2</td>
<td>Subsídios e prêmios</td>
<td>811 958</td>
<td>1%</td>
<td>811 958</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.1.3</td>
<td>Per diems deslocações</td>
<td>551 064</td>
<td>1%</td>
<td>551 064</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.2.0</td>
<td>Medicam. e consumíveis medic.</td>
<td>11 262 113</td>
<td>19%</td>
<td>8 220 412</td>
<td>3 041 701</td>
<td>4 471 292</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Medicamentos (incl contraceptivos)</td>
<td>6 622 593</td>
<td>11%</td>
<td>4 495 530</td>
<td>2 127 064</td>
<td>2 836 568</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Materiais e reagentes</td>
<td>3 840 960</td>
<td>6%</td>
<td>2 926 322</td>
<td>914 637</td>
<td>1 634 723</td>
</tr>
<tr>
<td>1.2.3</td>
<td>Vacinas</td>
<td>79 856</td>
<td>1%</td>
<td>79 856</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.3.0</td>
<td>Outros materiais de consumo</td>
<td>3 913 023</td>
<td>7%</td>
<td>3 913 023</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.3.1</td>
<td>Material escritório</td>
<td>374 899</td>
<td>1%</td>
<td>374 899</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.3.2</td>
<td>Consumíveis</td>
<td>60 702</td>
<td>1%</td>
<td>60 702</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.3.3</td>
<td>Complementos alimentícios</td>
<td>2 552 406</td>
<td>4%</td>
<td>2 552 406</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.3.4</td>
<td>Outros materiais de consumo</td>
<td>378 698</td>
<td>1%</td>
<td>378 698</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.4.0</td>
<td>Manutenção</td>
<td>4 226 844</td>
<td>4%</td>
<td>4 226 844</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.4.1</td>
<td>Infraestruturas</td>
<td>1 518 052</td>
<td>3%</td>
<td>1 518 052</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.4.2</td>
<td>Meios de transporte</td>
<td>499 848</td>
<td>1%</td>
<td>499 848</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.4.3</td>
<td>Equipamentos e materiais</td>
<td>408 944</td>
<td>1%</td>
<td>408 944</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.5.0</td>
<td>Serviços</td>
<td>914 244</td>
<td>2%</td>
<td>914 244</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.5.1</td>
<td>Telefona e fax</td>
<td>267 514</td>
<td>0%</td>
<td>267 514</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.5.2</td>
<td>Electricidade e água</td>
<td>376 198</td>
<td>1%</td>
<td>376 198</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.5.3</td>
<td>Seguros, taxas</td>
<td>70 723</td>
<td>0%</td>
<td>70 723</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.5.4</td>
<td>Outros serviços</td>
<td>206 809</td>
<td>0%</td>
<td>206 809</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.6.0</td>
<td>Formação e IEC/Comunic. social</td>
<td>1 284 435</td>
<td>2%</td>
<td>1 284 435</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.6.1</td>
<td>Formação contínua</td>
<td>867 123</td>
<td>1%</td>
<td>867 123</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.6.2</td>
<td>Comunicacao social/IEC</td>
<td>417 312</td>
<td>1%</td>
<td>417 312</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.0.0</td>
<td><strong>CUSTOS DE INVESTIMENTO</strong></td>
<td>34 048 674</td>
<td>57%</td>
<td>18 515 701</td>
<td>15 532 974</td>
<td>0</td>
</tr>
<tr>
<td>2.1.0</td>
<td>Engenharia</td>
<td>9 525 404</td>
<td>16%</td>
<td>241 731</td>
<td>9 283 673</td>
<td>0</td>
</tr>
<tr>
<td>2.1.1</td>
<td>Construções novas</td>
<td>6 501 911</td>
<td>11%</td>
<td>4 160 505</td>
<td>6 460 306</td>
<td>0</td>
</tr>
<tr>
<td>2.1.2</td>
<td>Reabilitações maiores</td>
<td>1 228 848</td>
<td>2%</td>
<td>55 752</td>
<td>1 173 096</td>
<td>0</td>
</tr>
<tr>
<td>2.1.3</td>
<td>Reabilitações menores</td>
<td>1 794 645</td>
<td>3%</td>
<td>144 374</td>
<td>1 650 271</td>
<td>0</td>
</tr>
<tr>
<td>2.2.0</td>
<td>Aquisição Meios de transporte</td>
<td>2 181 990</td>
<td>4%</td>
<td>1 552 922</td>
<td>629 068</td>
<td>0</td>
</tr>
<tr>
<td>2.2.1</td>
<td>Viaturas</td>
<td>1 677 830</td>
<td>3%</td>
<td>1 120 176</td>
<td>557 654</td>
<td>0</td>
</tr>
<tr>
<td>2.2.2</td>
<td>Motorizadas</td>
<td>360 064</td>
<td>1%</td>
<td>28 865</td>
<td>331 199</td>
<td>0</td>
</tr>
<tr>
<td>2.2.3</td>
<td>Bicicletas</td>
<td>60 864</td>
<td>0%</td>
<td>60 864</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.2.4</td>
<td>Embarcações</td>
<td>83 232</td>
<td>0%</td>
<td>83 232</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.3.0</td>
<td>Equipamentos</td>
<td>5 796 265</td>
<td>10%</td>
<td>3 735 799</td>
<td>2 060 467</td>
<td>0</td>
</tr>
<tr>
<td>2.3.1</td>
<td>Equipamentos medicais</td>
<td>3 143 393</td>
<td>5%</td>
<td>1 947 273</td>
<td>1 196 120</td>
<td>0</td>
</tr>
<tr>
<td>2.3.2</td>
<td>Medicamentos, estoque inicial</td>
<td>1 073 937</td>
<td>2%</td>
<td>20 959</td>
<td>864 347</td>
<td>0</td>
</tr>
<tr>
<td>2.3.3</td>
<td>Mobiliários</td>
<td>893 005</td>
<td>1%</td>
<td>893 005</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.3.4</td>
<td>Outros equipamentos</td>
<td>685 931</td>
<td>1%</td>
<td>685 931</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.4.0</td>
<td>Form. prof. e Comunic.Soc.</td>
<td>2 779 790</td>
<td>5%</td>
<td>2 779 790</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.4.1</td>
<td>Formação prof. inicial no país</td>
<td>1 030 400</td>
<td>2%</td>
<td>1 030 400</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.4.2</td>
<td>Bolsas de estudo (exterior)</td>
<td>916 744</td>
<td>2%</td>
<td>916 744</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.4.3</td>
<td>Missões para estrangeiro</td>
<td>832 646</td>
<td>1%</td>
<td>832 646</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.4.4</td>
<td>Comunicação Social</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.5.0</td>
<td>Assistência Técnica</td>
<td>13 765 225</td>
<td>23%</td>
<td>10 205 459</td>
<td>3 559 766</td>
<td>0</td>
</tr>
<tr>
<td>2.5.1</td>
<td>Assistência técnica de longa duração</td>
<td>11 307 453</td>
<td>19%</td>
<td>8 674 480</td>
<td>2 632 973</td>
<td>0</td>
</tr>
<tr>
<td>2.5.2</td>
<td>Serviços de consultores internacionais</td>
<td>2 041 449</td>
<td>3%</td>
<td>1 114 656</td>
<td>926 793</td>
<td>0</td>
</tr>
<tr>
<td>2.5.3</td>
<td>Consultorias locais</td>
<td>416 323</td>
<td>1%</td>
<td>416 323</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL GERAL</strong></td>
<td>60 133 914</td>
<td>100%</td>
<td>41 559 239</td>
<td>18 874 675</td>
<td>4 471 292</td>
<td></td>
</tr>
</tbody>
</table>
Annex 5

National Health Development Program

Financial Summary

Years Ending December 31
(in million US$, base year: 1997)

<table>
<thead>
<tr>
<th></th>
<th>Implementation Period</th>
<th>Operational Period</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment Costs</td>
<td>5.4 6.9 7.5 7.6 7.0 6.8 41.0</td>
<td>- - - - -</td>
</tr>
<tr>
<td>Recurrent Costs</td>
<td>4.0 4.1 4.2 4.3 4.3 25.1</td>
<td>3.4 3.4 3.5 3.6 3.6</td>
</tr>
<tr>
<td>Total</td>
<td>9.4 11.0 11.7 11.8 11.3 11.1 66.1</td>
<td>3.4 3.4 3.5 3.6 3.6</td>
</tr>
<tr>
<td><strong>Financing Sources</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IDA</td>
<td>1.1 3.4 4.1 3.7 3.0 2.4 17.7</td>
<td>- - - - -</td>
</tr>
<tr>
<td>Co-financiers</td>
<td>9.2 9.2 9.2 9.4 9.4 9.4 55.8</td>
<td>- - - - -</td>
</tr>
<tr>
<td>Government Beneficiaries</td>
<td>3.2 3.2 3.3 3.3 3.3 3.3 19.7</td>
<td>4.1 4.1 4.1 4.2 4.2</td>
</tr>
<tr>
<td>Total</td>
<td>14.1 16.6 17.7 17.8 17.0 16.8 100.0</td>
<td>5.1 5.1 5.3 5.4 5.4</td>
</tr>
</tbody>
</table>
Procurement

No special exceptions, permits, or licenses need to be specified in the Credit documents for International Competitive Bidding (ICB), since Guinea-Bissau’s procurement practices allow IDA procedures to take precedence over any contrary provisions in local regulations. Procurement of works, goods and services financed by the IDA credit will be carried out in accordance with the Guidelines: Procurement under IBRD Loans and IDA Credits (January 1995, revised in January and August 1996). Consultants services contracts financed by IDA will be procured in accordance with Bank’s Guidelines for the Selection of Consultants by the World Bank Borrowers published in January 1997. National Competitive Bidding (NCB) advertised locally would be carried out in accordance with Guinea-Bissau’s procurement laws and regulations, acceptable to IDA provided that: (i) any bidder is given sufficient time to submit bids (three to four weeks); (ii) bid evaluation and bidder qualification are clearly specified in bidding documents; (iii) no preference margin is granted to domestic manufacturers; (iv) eligible firms are not precluded from participation; (v) award will be made to the lowest evaluated bidder; and (vi) prior to issuing the first call for bids, draft standard bidding documents are submitted to IDA and found acceptable. IDA’s Standard Bidding Documents (SBD) will be used for ICB procurements. Bidding documents agreed upon by IDA and used for National Competitive Bidding (NCB) in the Social Sector Project (SSP) will be used for National Competitive Bidding (NCB) procurements under the Program. The Bank’s Standard Forms of Contract for Consultant Services will also be used where applicable. One ICB contract document and one NCB document for procurement of civil works and goods have been reviewed and approved by IDA during appraisal and negotiations. All of the above document formats are available in computerized format. As part of the Program Implementation Manual, the MOPH is preparing a draft procurement/disbursement plan for review by IDA and other donors. The plan will be reviewed and updated at least one month prior to the start of each program year.

Procurement under the program will be handled by the DAF in DGPC, with the assistance of short-term consultants and of the Program manager. In order to reduce the workload of the DAF and the need for consultants, the implementation of all civil works (construction and rehabilitation) financed by the IDA credit (and also by other donors interested in such arrangements) will be delegated by MOPH during the first two program years to the local Construction Management Agency (AGEOPPE), which will contract out consultants services for the preparation of detailed design and bidding documents and to contractors for the execution of the works. The DCPS in the DGSP and the regions for the health centers, and the DSH in the DGSP and the hospitals themselves for the hospitals, will be responsible for the overall planning of the works, the availability of land (if required), the preparation of the technical specifications and any other information needed by AGEOPPE to prepare the detailed design and bidding documents. Also, to facilitate small and urgent procurement may be done through IAPSO for specialized equipment and through UNIPAC or other non-governmental organizations (as long as it is the least cost solution) for drugs -- in accordance with the provisions described below for the procurement of goods. For all other procurement handled by DAF, the procurement methods described below and summarized in Table A will apply.

The total cost of civil works is estimated at US$ 11.8 million for the whole five year-program. Civil works contracts financed by IDA during the two first program years are for the construction and rehabilitation of health facilities and other infrastructures in the regions, including Bissau. They are estimated to cost less than US$100,000 per contract, up to an aggregate amount of US$1.09 million, and would be procured through NCB procedures applicable to AGEOPPE, and described in the Manual of Procedures which is acceptable to IDA. AGEOPPE will maintain a roster of contractors eligible for NCB, according to procedures acceptable to IDA, as spelled out in the Manual of Procedures. Contracts for small works estimated to cost less than US$20,000 per contract, up to an aggregate amount of US$100,000, may be procured under lump-sum, fixed price contracts awarded on the basis of quotations obtained from three qualified
domestic contractors invited to bid by way of discounts either on the total price or the on the unit price. The invitation
shall include reference unit prices established by an engineer, a detailed description of the works, including basic
specifications, the required completion date, a basic form of agreement acceptable to IDA, and relevant drawings where
applicable. The award would be made to the contractor who offers the lowest price quotation for the required work,
provided he demonstrates he has the experience and resources to complete the contract successfully. These contracts
would mostly be for works relating to small construction in rural health areas.

The total cost of goods is estimated at US$ 19.2 million, including health equipment kits, hospital furniture,
equipment and supplies, training center equipment and supplies, warehouse stacking and operational equipment,
transport vehicles, pharmaceuticals, laboratory reagents and medical supplies, textbooks and learning materials, and
office furniture, equipment, technology supplies and fuel. Procurements will be bulked where feasible into packages
valued at US$ 100,000 or more and will be procured through ICB. Procurement of office furniture, vehicles and fuel
valued at less than US$ 100,000 up to an aggregate total of US$ 0.32 million will be procured through NCB.
Implementation of the program would require the purchase of relatively small, primarily consumable items, by MOPH
local offices, regional authorities and communities around the country, which would be difficult and impractical to
package and procure following NCB procedures. Thus, such items (mostly pharmaceuticals and medical equipment)
which could not be grouped into ICB packages and costing less than US$100,000 per contract, up to an aggregate amount
not to exceed US$1.45 million over the project duration, would be procured respectively through (UNIPAC) and through
the Inter-Agency Procurement Services of the UNDP (IAPSO); this would be the most economical and efficient way of
procuring small quantities in particular in case of emergency. Procurement of small equipment, furniture and vehicles
costing less than US$20,000 equivalent per contract up to an aggregate of US$50,000 may be procured through prudent
local shopping, or up to US$50,000 through international shopping on the basis of quotations obtained from at least three
reputable suppliers. Spare parts, operating expenditures, minor off-the-shelf items, pharmaceuticals and other proprietary
items costing less than US$5,000 equivalent per contract up to an aggregate amount not to exceed US$20,000 equivalent,
may be procured directly from manufacturers and authorized local distributors.

Consultants' Services and Training financed by IDA during the first two program years would be for: (i)
studies, preparation of bidding documents, data collection, accounting systems, audit and impact analysis; (ii) long
term technical assistance, short term consultancies on specific technical matters and training; and (iii) training of health
personnel staff. Consultants financed by IDA, totaling US$2.8 million, would be hired in accordance with the Bank’s
Guidelines for Selection and Employment of Consultants by World Bank Borrowers dated January, 1997. It will be
addressed through competition among qualified short-listed firms in which the selection will be based on Quality-and
Cost-Based Selection (QCBS) by evaluating the quality of the proposal before comparing the cost of the services to be
provided. For audits of a standard nature the Least-Cost Selection (LCS) will be the most appropriate method -- the
firm with the lowest price will be selected, provided its technical proposal received the minimum mark. Consultants
services for hospital advisory services and health financing (estimated at less than US$100,000 per contract up to an
aggregate of US$300,000) would be based on Consultants’ Qualifications (CQ) based only on the consultants’
experience and competence relevant to the assignment. The Government of Guinea-Bissau proposed to select AGEOPPE
on a Single Source Selection basis as Construction Management Agency (CMA) for the first two program years which
is acceptable to IDA. In the event that another entity would have to be selected after this period as CMA, it would be
done through QCBS procedures. Services for lectures and small studies which can be delivered by Individual
Consultants will be selected through comparison of qualifications against job description requirements among those
expressing interest in the assignment or approached directly. To ensure that priority is given to the identification of
suitable and qualified national individual consultants, the selection process will first be limited to nationals of Guinea-
Bissau, this will also imply significant cost savings. It is only when no suitable national candidates are identified that
international consultants who expressed interest in the assignment will be considered. Fellowship, research grants will be
awarded in accordance with the consultants guidelines as described above.
Short-lists for contracts estimated under US$200,000 may be comprised entirely of national consultants if a sufficient number of qualified firms (at least three) are available at competitive costs. However, if foreign firms have expressed interest, they will not be excluded from consideration. The standard Letter of Invitation and Form of Contract as developed by the Bank will be used for appointment of consultants. Simplified contracts will be used for short-term assignments, i.e. those not exceeding six months, carried out by individual consultants. The Government was briefed during negotiations about the special features of the new guidelines, in particular with regards to advertisement and public bid opening.

The second phase of health staff training will be contracted to the institution (ICBAS) which was originally selected under the on-going project in accordance with IDA short-list procedures. Following IDA no-objection to select ICBAS, the contract was divided in two phases, due to shortage of resources under the ongoing IDA financed SSP and the closing thereof which would have fallen before the completion of the training. This will ensure continuity in the technical approach and professional liability with regard to the outcomes of this training. However, the second phase contract will be signed only after ascertaining satisfactory performance during the first phase.
Table A: Program Costs by Procurement Arrangements for the first two program years (in US$ million equivalent including taxes, duties and contingencies)

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>Procurement Method</th>
<th>Total Cost (including contingencies)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ICB</td>
<td>NCB</td>
</tr>
<tr>
<td>1. Works</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 for health centers</td>
<td>-</td>
<td>0.73</td>
</tr>
<tr>
<td>1.2 other civil works</td>
<td>-</td>
<td>0.26</td>
</tr>
<tr>
<td>boreholes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Goods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 medical equipment</td>
<td>0.20</td>
<td>0.32</td>
</tr>
<tr>
<td>2.2 equipment/furniture, vehicles</td>
<td>-</td>
<td>0.32</td>
</tr>
<tr>
<td>2.3 stock initial</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2.4 replenishment medicaments</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 CW contract</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>management and audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 TA, Training, studies, short term consultancies</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Miscellaneous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 operating costs</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4.2 PPF refinancing</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Costs</td>
<td>0.20</td>
<td>1.31</td>
</tr>
<tr>
<td>Total Financed by IDA</td>
<td>(0.20)</td>
<td>(1.26)</td>
</tr>
</tbody>
</table>

Note: N.B.F. = Not Bank-financed.
Figures in parenthesis are the amounts to be financed by the Bank loan/IDA credit.
IDA Review. All contracts for construction of civil works and purchase of goods above the threshold value of US$100,000 will be subject to IDA’s prior review procedures. The use of IDA’s SBD would considerably expedite the prior review process as IDA review would primarily focus on invitation to bid, bid data sheet, contract data, technical specifications, bill of quantities/schedule of requirements and other contract-specific items. The review process would cover about 80 percent of the total value of the amount contracted for goods and about 60 percent of the amount contracted for civil works. Selective post-review of contracts awarded below the threshold levels will apply to about one in three contracts. Draft standard bidding documents for NCB were reviewed by and agreed upon with IDA during negotiations. The provisions of the Consultant Guidelines requiring prior IDA review or approval of budgets, short lists, selection procedures, letters of invitation, proposals, evaluation reports and contracts shall not apply to contracts with firms estimated to cost less than US$ 100,000 and with individuals estimated to cost less than US$ 50,000 each. Prior IDA review will not apply to contracts for the recruitment of consulting firms and individuals estimated to cost less than US$100,000 and US$50,000 equivalent respectively. However, the exception to prior IDA review will not apply to the Terms of Reference of such contracts, regardless of value, to single-source hiring, to assignments of a critical nature as determined by IDA or to amendments of contracts raising the contract value above the prior review threshold. For consultant contracts estimated above US$200,000, opening the financial envelopes will not take place prior to receiving the Bank’s no-objection to the technical evaluation. For contracts estimated to cost less than US$200,000 and more than US$100,000 the borrower will notify IDA of the results of the technical evaluation prior to opening the financial proposals. Documents related to procurement below the prior review thresholds will be maintained by the borrower for ex-post review by auditors and by IDA supervision missions. The MOPH will be required to maintain all relevant procurement documentation for subsequent review by IDA. The MOPH will submit to IDA periodic procurement schedules detailing each procurement in progress and completed as part of the normal project reporting exercise.

All thresholds stated in this section shall be reviewed by the Borrower and IDA on an annual basis. Modifications may be agreed upon based on performance and actual values of procurements implemented. Amendments to the Credit agreement may be prepared as necessary.

Table B: Thresholds for Procurement Methods and Prior Review

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>Contract Value (Threshold)</th>
<th>Procurement Method</th>
<th>Contracts Subject to Prior Review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ICB</td>
<td>NCB</td>
<td>Other</td>
</tr>
<tr>
<td>1. Works</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>above US$ 100,000</td>
<td>X</td>
<td>-</td>
<td>- Prior IDA review</td>
</tr>
<tr>
<td>below US$ 100,000</td>
<td>-</td>
<td>X</td>
<td>- No review. Aggregate amount: US$990,000</td>
</tr>
<tr>
<td>above US$ 20,000</td>
<td>-</td>
<td>-</td>
<td>X No review. Aggregate amount: US$100,000</td>
</tr>
<tr>
<td>below US$ 20,000</td>
<td>-</td>
<td>-</td>
<td>X No review. Aggregate amount: US$100,000</td>
</tr>
<tr>
<td>2. Goods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>above US$ 100,000</td>
<td>X</td>
<td>-</td>
<td>- Prior IDA review</td>
</tr>
<tr>
<td>below US$ 100,000</td>
<td>-</td>
<td>X</td>
<td>- No review. Aggregate amount: US$320,000</td>
</tr>
<tr>
<td>above US$ 20,000</td>
<td>-</td>
<td>-</td>
<td>IAPSO or UNIPAC No review. Aggregate amount: US$1.45 million</td>
</tr>
<tr>
<td>below US$100,000</td>
<td>-</td>
<td>-</td>
<td>IAPSO or UNIPAC No review. Aggregate amount: US$1.45 million</td>
</tr>
<tr>
<td>below US$ 20,000</td>
<td>-</td>
<td>-</td>
<td>X No review aggregate</td>
</tr>
</tbody>
</table>
As a condition of effectiveness, the Government will submit a procurement plan for the first two project years. During negotiations, the Government submitted to IDA: (a) a draft Operational Manual for Project Management and Implementation including target time periods for the various procurement phases; and (b) standard bidding documents to be used under NCB procedures for civil works and goods. Agreement was also reached on the proper monitoring of procurement, as well as the standard procurement documents to be used for NCB. The Government gave assurance at negotiations that it would (a) use the Operational Manual for Project Implementation; (b) use the Bank’s Standard Bidding Documents for ICB; (c) apply the procurement procedures and arrangements outlined in the above documents; and (d) review the procurement plan and procurement arrangements each year at the annual review with IDA and other donors. During implementation, all bidding documents, bid evaluation reports, and draft contracts transmitted to IDA for review will contain an updated copy of the procurement planning. Procurement information will be collected and recorded as follows:
(a) prompt recording of contract award information by the Borrower; and

(b) semi-annual reports to the Bank by the Borrower indicating: (i) revised cost estimates for individual contracts and the total project, including best estimates of allowances for contingencies; (ii) revised timing of estimated procurement actions, including experience with completion time and completion cost for individual contracts; and (iii) compliance with aggregate limits on specified methods of procurement.

A detailed procurement plan for works, goods and services to be procured under the two first project years was prepared and is annexed to the implementation manual. It will be reviewed and updated on a regular basis during annual reviews. The Government gave assurance at negotiations that it would take the necessary measures to ensure that procurement phases do not exceed the following target time periods:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Maximum number of weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of bidding documents</td>
<td>4 (12 for large contracts)</td>
</tr>
<tr>
<td>Preparation of bids by bidders</td>
<td>4 (6 for ICB)</td>
</tr>
<tr>
<td>Bid evaluation</td>
<td>2 (4 for large contracts)</td>
</tr>
<tr>
<td>Signature of contracts</td>
<td>2</td>
</tr>
<tr>
<td>Payments</td>
<td>4</td>
</tr>
</tbody>
</table>

**Disbursement**

The proposed allocation of the credit is shown in Table C. The IDA credit will be disbursed over a period of six years (from 1998 to 2003), with a closing date of December 31, 2003. The estimated disbursement schedule is shown in Table D. All applications to withdraw proceeds from the credit will be fully documented, except for contracts not subject to prior review by IDA. For the rest, disbursements will be made against Statements of Expenditures (SOEs) certified by MOPH or AGEOPPE. Supporting documentation will be retained by MOPH or AGEOPPE and will be available for review as requested by IDA supervision missions and program auditors.
Table C: Allocation of Credit Proceeds

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>Amount in US$ million</th>
<th>Financing Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Works</td>
<td>1.10</td>
<td>95%</td>
</tr>
<tr>
<td>2. Goods (including Medical equipment, drugs, reagents, office equipment, vehicles, and furniture)</td>
<td>2.08</td>
<td>100% of foreign and 95% of local expenditures</td>
</tr>
<tr>
<td>3. Services (including long term TA, short term consultancy, civil works contract management and training)</td>
<td>2.80</td>
<td>100%</td>
</tr>
<tr>
<td>4. Operating Costs</td>
<td>0.27</td>
<td>95%</td>
</tr>
<tr>
<td>5. Unallocated</td>
<td>5.24</td>
<td>---</td>
</tr>
<tr>
<td>6. PPF</td>
<td>0.21</td>
<td>---</td>
</tr>
<tr>
<td><strong>Total IDA credit</strong></td>
<td><strong>11.70</strong></td>
<td></td>
</tr>
</tbody>
</table>

* Operating costs include incremental operating costs incurred on account of program implementation, management and supervision, including office supplies, office equipment and vehicles operation and maintenance and travel and allowances including those for trainers and trainees, but excluding salaries of officials of the borrower’s civil service.

Table D: Estimated Disbursements of IDA Credit (US$ million)

<table>
<thead>
<tr>
<th>IDA Fiscal Year</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual</td>
<td>0.75</td>
<td>2.25</td>
<td>2.70</td>
<td>2.45</td>
<td>1.95</td>
<td>1.60</td>
</tr>
<tr>
<td>Cumulative</td>
<td>0.75</td>
<td>3.00</td>
<td>5.70</td>
<td>8.15</td>
<td>10.10</td>
<td>11.70</td>
</tr>
</tbody>
</table>

A Special Account will be opened for the IDA credit and maintained with a commercial bank, acceptable to IDA. The maximum balance in the Special Account will be US$300,000, which will cover about 4 months of expenditures, including advance to AGEOPPE on account of civil works program, to be disbursed from the Special Account.
### PLAN PROVISOIRE DE FINANCEMENTIDA ET BAD DU PNDS

**PNDS - PLAN PROVISOIRE DE FINANCEMENT IDA ET BAD**

#### Valores em milhões de dólares

<table>
<thead>
<tr>
<th>Rubricas de Despesa</th>
<th>IDA</th>
<th>BAD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1.0 Compras</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.1.0.1 Compra de Materiais e Equipamentos</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.1.0.2 Serviços</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1.1.0.3 Outros Previ-de Investimento</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td><strong>1.1.4 Material de Instrução</strong></td>
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<td><strong>6.0.0 Compor de Diversificado</strong></td>
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<td>3 949</td>
<td>2 646</td>
<td>6 695</td>
<td>5 997</td>
<td>11 646</td>
<td>14 181</td>
<td>25 817</td>
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**Nota:** Os dados são apresentados em milhões de dólares. Os valores específicos variam de acordo com as rubricas e os anos de implantação.
Annex 7  
National Health Development Program  
Project Processing Budget and Schedule

A. Program Budget (US$000)  

<table>
<thead>
<tr>
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<th>Planned</th>
<th>Actual</th>
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B. Program Schedule  

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<th>Time taken to prepare the program (months)</th>
<th>Planned</th>
<th>Actual</th>
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<td>First Bank mission (identification)</td>
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<td>10/23/95</td>
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<td>Appraisal mission departure</td>
<td>6/23/97</td>
<td>06/23/97</td>
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<tr>
<td>Negotiations</td>
<td>9/22/97</td>
<td>10/06/97</td>
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<td>Planned Date of Effectiveness</td>
<td>1/2/98</td>
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Prepared by: Ministry of Public Health (MOPH).
Preparation assistance: on going Social Sector Project; PHRD Grant; PPF; co-financiers.

Bank staff who worked on the project included: Mmes/Messrs Tonia Marek, Task Manager; Eugene Boostrom, Senior Public Health Specialist; Jo Martins, Senior Health Economist; Slaheddine Ben-Halima, Senior Operations Officer, Marie-Madeleine Ndaw, Task Team Assistant at Senegal Resident Mission; Rudi Chevannes, Task Team Assistant at Headquarters; and Paul Geli, Consultant, Institutional Development.
Annex 8
National Health Development Program
Documents in the Project File

A. Program Implementation Plan


B. Bank Staff Assessments

- Economic Analysis, by Gérard Schmets, June 1997

C. Other


* Including electronic files.
## Annex 9
### Statement of Loans and Credits

**Status of Bank Group Operations in Guinea-Bissau**

**IBRD Loans and IDA Credits in the Operations Portfolio**

<table>
<thead>
<tr>
<th>Project ID</th>
<th>Loan or Credit No.</th>
<th>Fiscal Year</th>
<th>Borrower</th>
<th>Purpose</th>
<th>Original Amount in US$ Millions</th>
<th>Difference Between expected and actual disbursements a/</th>
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<tr>
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<td></td>
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<td>IBRD</td>
<td>IDA</td>
</tr>
<tr>
<td>Number of Closed Loans/credits: 19</td>
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### Active Loans

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<th>Project ID</th>
<th>Loan or Credit No.</th>
<th>Fiscal Year</th>
<th>Borrower</th>
<th>Purpose</th>
<th>Original Amount in US$ Millions</th>
<th>Difference Between expected and actual disbursements a/</th>
</tr>
</thead>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>IBRD</td>
<td>IDA</td>
</tr>
<tr>
<td>GW-PE-1015</td>
<td>IDA29600</td>
<td>1997</td>
<td>GOVT OF GUB</td>
<td>BASIC EDUCATION</td>
<td>0.00</td>
<td>14.30</td>
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<tr>
<td>GW-PE-35915</td>
<td>IDA27480</td>
<td>1995</td>
<td>REPUBLIC OF GUB</td>
<td>TRANSP. &amp; URBAN INFRA</td>
<td>0.00</td>
<td>22.00</td>
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<tr>
<td>GW-PE-1002</td>
<td>IDA24650</td>
<td>1993</td>
<td>GOVT OF GUI-BISSAU U</td>
<td>SOCIAL</td>
<td>0.00</td>
<td>8.80</td>
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<tr>
<td>GW-PE-1011</td>
<td>IDA23420</td>
<td>1992</td>
<td>GOVERNMENT OF GUB</td>
<td>TECHNICAL ASSISTANCE</td>
<td>0.00</td>
<td>7.20</td>
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<tr>
<td>GW-PE-1000</td>
<td>IDA22370</td>
<td>1991</td>
<td>GOVERNMENT</td>
<td>ENERGY</td>
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<td>15.15</td>
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<tr>
<td>Total</td>
<td></td>
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<td>0.00</td>
<td>67.45</td>
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</table>

### Total Disbursed (IBRD and IDA):

- of which has been repaid:
  - 0.00
- Total now held by IBRD and IDA:
  - 67.45
- Amount sold:
  - 0.00
- Of which repaid:
  - 0.00

### Total Undisbursed:

- 30.58

---

a. Intended disbursements to date minus actual disbursements to date as projected at appraisal.

Note:
Disbursement data is updated at the end of the first week of the month.
Guinea-Bissau

STATEMENT OF IFC's
Committed and Disbursed Portfolio
As of 31-Jul-97
(In US Dollar Millions)

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<tr>
<th>FY Approval</th>
<th>Company</th>
<th>Committed IFC</th>
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<th></th>
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<th>Disbursed IFC</th>
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<tr>
<td></td>
<td></td>
<td>Loan</td>
<td>Equit</td>
<td>Quasi</td>
<td>Partic</td>
<td>Loan</td>
<td>Equit</td>
<td>Quasi</td>
<td>Partic</td>
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<tr>
<td>1994</td>
<td>AEF Agribissau</td>
<td>.75</td>
<td>.09</td>
<td>0.00</td>
<td>0.00</td>
<td>.75</td>
<td>.09</td>
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<td>0.00</td>
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<tr>
<td></td>
<td>Total Portfolio:</td>
<td>.75</td>
<td>.09</td>
<td>0.00</td>
<td>0.00</td>
<td>.75</td>
<td>.09</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td></td>
<td>Approvals Pending Commitment</td>
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<td>Loan</td>
<td>Equit</td>
<td>Quasi</td>
<td>Partic</td>
<td></td>
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<tr>
<td></td>
<td>Total Pending Commitment:</td>
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<td>0.00</td>
<td>0.00</td>
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<td></td>
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</table>
Guinea-Bissau at a glance

**POVERTY and SOCIAL**

- **Population mid-1996 (millions)**
  - Guinea-Bissau: 1.1
  - Sub-Saharan Africa: 0.6
  - Low-income: 3.229
- **GNP per capita 1996 (US$)**
  - Guinea-Bissau: 250
  - Sub-Saharan Africa: 490
  - Low-income: 500
- **GNP 1996 (billions US$)**
  - Guinea-Bissau: 0.27
  - Sub-Saharan Africa: 294
  - Low-income: 1,601

**Average annual growth, 1990-96**

- **Population (%)**
  - Guinea-Bissau: 2.1
  - Sub-Saharan Africa: 2.7
  - Low-income: 1.7
- **Labor force (%)**
  - Guinea-Bissau: 1.8
  - Sub-Saharan Africa: 2.6
  - Low-income: 1.7

**Most recent estimate (latest year available since 1989)**

- **Poverty headcount index (% of population)**
  - Guinea-Bissau: 49
- **Urban population (% of total population)**
  - Guinea-Bissau: 22
  - Sub-Saharan Africa: 31
  - Low-income: 29
- **Life expectancy at birth (years)**
  - Guinea-Bissau: 44
  - Sub-Saharan Africa: 52
  - Low-income: 63
- **Child malnutrition (% of children under 5)**
  - Guinea-Bissau: 35
  - Sub-Saharan Africa: 65
  - Low-income: 98
- **Access to safe water (% of population)**
  - Guinea-Bissau: 47
  - Sub-Saharan Africa: 53
  - Low-income: 53
- **Illiteracy (% of population age 15+)**
  - Guinea-Bissau: 44
  - Sub-Saharan Africa: 52
  - Low-income: 53
- **Gross primary enrollment (% of school-age population)**
  - Guinea-Bissau: 50
  - Sub-Saharan Africa: 72
  - Low-income: 105

**KEY ECONOMIC RATIOS and LONG-TERM TRENDS**

- **GDP (millions US$)**
  - 1976: 109.0
  - 1985: 157.7
  - 1995: 253.9
  - 1996: 271.2
- **Gross domestic investment/GDP**
  - 1976: 15.4
  - 1985: 40.8
  - 1995: 22.9
  - 1996: 26.9
- **Exports of goods and services/GDP**
  - 1976: 5.2
  - 1985: 8.9
  - 1995: 11.7
  - 1996: 10.5
- **Gross domestic savings/GDP**
  - 1976: -5.4
  - 1985: -2.9
  - 1995: -0.6
  - 1996: 5.7
- **Gross national savings/GDP**
  - 1976: -3.1
  - 1985: -3.9
  - 1995: -0.6
  - 1996: 6.7
- **Current account balance/GDP**
  - 1976: 7.2
  - 1985: 197.2
  - 1995: 351.0
  - 1996: 334.9
- **Net debt/GDP**
  - 1976: -41.8
  - 1985: -16.1
  - 1995: -14.6
  - 1996: -10.5
- **Net debt service/GDP**
  - 1976: 1.0
  - 1985: 1.4
  - 1995: 1.8
  - 1996: 1.5
- **Net debt service/export**
  - 1976: 7.2
  - 1985: 52.6
  - 1995: 35.1
  - 1996: 31.7
- **GDP per capita (US$)**
  - 1976: 44
  - 1985: 40.8
  - 1995: 271.2
  - 1996: 271.2
- **GNP per capita (US$)**
  - 1976: 250
  - 1985: 490
  - 1995: 500
  - 1996: 500

**STRUCTURE of the ECONOMY**

- **Agriculture**
  - 1976: 47.8
  - 1985: 42.4
  - 1995: 55.1
  - 1996: 53.6
- **Industry**
  - 1976: 25.4
  - 1985: 14.3
  - 1995: 12.2
  - 1996: 10.9
- **Services**
  - 1976: 26.9
  - 1985: 43.3
  - 1995: 32.7
  - 1996: 35.3
- **Private consumption**
  - 1976: 82.5
  - 1985: 86.6
  - 1995: 92.0
  - 1996: 85.1
- **General government consumption**
  - 1976: 22.9
  - 1985: 16.4
  - 1995: 8.7
  - 1996: 9.2
- **Imports of goods and services**
  - 1976: 25.9
  - 1985: 52.6
  - 1995: 35.1
  - 1996: 31.7

**Growth rates of output and investment (%)**

- **Agriculture**
  - 1976-86: 0.0
  - 1986-96: 1.4
  - 1996: 1.8
  - 1997-06: 2.1

**Note:** 1996 data are preliminary estimates. Figures in italics are for years other than those specified.

*The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.*
PRICES and GOVERNMENT FINANCE

### Domestic prices
- **(% change)**
  - Consumer prices: 45.4, 56.6
  - Implicit GDP deflator: 48.1, 48.3

### Government finance
- **(% of GDP)**
  - Current revenue: 27.5, 28.3, 13.0, 7.9
  - Overall surplus/deficit: -36.5, -2.1, -12.2

### TRADE
- **(millions US$)**
  - Total exports (fob): 24, 22, 100
    - Cashew Nuts: 5, 21, 19
    - Fish and Shrimps: 3, 0, 1
    - Manufactures: 69, 72, 69
  - Total imports (cif): 69, 72, 69
    - Food: 17, 26, 22
    - Fuel and energy: 9, 8, 9
    - Capital goods: 13, 16, 13
    - Export price index (1987=100): 82, 96
    - Import price index (1987=100): 134, 127
    - Terms of trade (1987=100): 61, 68

### BALANCE of PAYMENTS
- **(millions US$)**
  - Exports of goods and services: 20, 30, 29
  - Imports of goods and services: 89, 86
  - Resource balance: 3, 0, 1
    - Net income: -5, -7, -5
    - Net current transfers: 1, 25, 23
  - Current account balance:
    - before official capital transfers: -66, -60, -57
  - Financing items (net): 53, 41, 51
  - Changes in net reserves: -17, 0
  - Memo: Reserves including gold (mill. US$): 22, 24
  - Conversion rate (local/US$): 41.4, 160.0

### EXTERNAL DEBT and RESOURCE FLOWS
- **(millions US$)**
  - Total debt outstanding and disbursed: 8, 311, 891, 908
    - IBRD: 0, 0, 0, 0
    - IDA: 0, 44, 210, 224
  - Total debt service: 9, 14, 20
    - IBRD: 0, 0, 0
    - IDA: 0, 0, 2
  - Composition of net resource flows:
    - Official grants: 0, 0, 0
    - Official creditors: 8, 38, 13
    - Private creditors: 0, 20, 0
    - Foreign direct investment: 0, 0, 0
    - Portfolio equity: 0, 0, 0
  - World Bank program:
    - Commitments: 0, 0, 22
    - Disbursements: 0, 15, 11
    - Principal repayments: 0, 0, 1
    - Net flows: 0, 15, 10
    - Interest payments: 0, 0, 1
    - Net transfers: 0, 14, 9

---

**Guinea-Bissau**

**PRICES and GOVERNMENT FINANCE**

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<td>Implicit GDP deflator</td>
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**Government finance (% of GDP)**

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<td>Current revenue</td>
<td>27.5</td>
<td>28.3</td>
<td>13.0</td>
<td>7.9</td>
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<tr>
<td>Overall surplus/deficit</td>
<td>-36.5</td>
<td>-2.1</td>
<td>-12.2</td>
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**TRADE**

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<td>Cashew Nuts</td>
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<td>Manufactures</td>
<td>69</td>
<td>72</td>
<td>69</td>
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<tr>
<td>Total imports (cif)</td>
<td>69</td>
<td>72</td>
<td>69</td>
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<tr>
<td>Food</td>
<td>17</td>
<td>26</td>
<td>22</td>
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<td>Fuel and energy</td>
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<tr>
<td>Capital goods</td>
<td>13</td>
<td>16</td>
<td>13</td>
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<tr>
<td>Export price index (1987=100)</td>
<td>82</td>
<td>96</td>
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<tr>
<td>Import price index (1987=100)</td>
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<td>Terms of trade (1987=100)</td>
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<td>68</td>
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**BALANCE of PAYMENTS**

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<td>Exports of goods and services</td>
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<td>29</td>
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<tr>
<td>Imports of goods and services</td>
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<td>Resource balance</td>
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<td>Net income</td>
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<tr>
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<td>Memo: Reserves including gold (mill. US$)</td>
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<td>Conversion rate (local/US$)</td>
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**EXTERNAL DEBT and RESOURCE FLOWS**

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<td>Total debt outstanding and disbursed</td>
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<td>Private creditors</td>
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<td>Net transfers</td>
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<td>14</td>
<td>9</td>
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</tbody>
</table>

---

**Guinea-Bissau**

**Inflation (%)**

- GDP def: □
- CPI: ○

**Export and Import levels (mill. US$)**

- Exports: □
- Imports: ○

**Current account balance to GDP ratio (%)**

- Exports of goods and services: 30 |
- Imports of goods and services: 86 |
- Resource balance: 29 |
- Net income: -5 |
- Net current transfers: 25 |
- Current account balance: -27 |
- Financing items (net): 83 |
- Changes in net reserves: -17 |

**Composition of total debt, 1996 (mill. US$)**

- IBRD: 224
- IDA: 684
- Other multilateral: 8
- Private: 8
- IME: 4
- Short-term: 2

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8/25/97
MAP SECTION