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

Concept Stage | Date Prepared/Updated: 19-Jun-2017 | Report No: PIDISDSC19941

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Angola	P160948		Angola Health System Performance Strengthening Project (HSPSP) (P160948)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	Nov 16, 2017	Jan 22, 2018	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Finance,Republic of Angola	Ministry of Health	

Proposed Development Objective(s)

The Project Development Objective (PDO) is to increase the utilization and the quality of health care services in target provinces and municipalities.

Financing (in USD Million)

Financing Source	Amount
International Bank for Reconstruction and Development	100.00
Total Project Cost	**100.00**

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

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

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Nearly forty years of conflict in Angola from 1961 to 2002 severely damaged the country's infrastructure, its public administration network and social fabric.** Conflict with the Portuguese colonial power in 1961, followed by independence from Portugal in 1975, and a protracted civil work for over 40 years, has been one of the bloodiest civil conflicts in Africa, ending on April 4, 2002. The war left behind a destroyed infrastructure (roads, railways, and bridges built during Portuguese rule), a decimated agricultural infrastructure, and torn the social fabric. The country was subsequently left without a functioning health-care system (its infant and child mortality rate were and still are worse than those for comparable countries[1]), with some of the lowest primary school enrollment rates [gross and net] compared to Sub-Saharan Africa (SSA) and Lower Income Countries (LMIC)[2], and very limited information/data from which to support policies and decision-making processes.[3]

2. **Following four decades of conflict, Angola has experienced over the last decade, rapid economic growth due to oil resources.** Angola is one of the largest countries in Sub Saharan Africa (SSA) and the region's second largest oil producer. In 2014, Angola's population was estimated at 24 million, with over 27 percent living in and around the capital city of Luanda, 33 percent in other urban centers, and 40 percent in rural areas. The rise of the oil sector has driven a steady increase in GDP per capita and its ensuing classification as an upper-middle-income country (UMIC). Between 2004 and 2014, the Angolan economy expanded at an annual average rate of 7.9 percent.

3. **The benefits of a burgeoning oil sector have not been felt across the population, as poverty remains widespread.** The conflict period in Angola triggered massive migration from rural to urban areas and exacerbated geographic disparities in income, opportunities, and human capital. Poverty remains widespread and a large portion of the population does not have access to basic services. Progress was made in reducing poverty rates: 36.6 percent of the population lived below the national poverty line of US$64 per month in 2008, down from 62 percent in 2001. Despite this progress, only roughly half of Angolans currently have access to improved water sources and sanitation facilities. Today, Angola ranks 150 of 188 countries on the UN Human Development Index, despite its classification as an UMIC.

4. **The recent collapse of global oil prices has had a deeply negative effect on the Angolan economy and social services.** The protracted slump in oil prices has drastically reduced public revenues, undermining the fiscal balances and threatening to undo recent economic and social development progress. The country's per capita growth rate is estimated to have been close to zero in 2014 and negative during 2015 and 2016. Falling oil prices have both directly reduced oil revenue and indirectly impacted non-oil revenue through their second-order effects on overall economic growth. This has resulted in serious fiscal imbalances and a rising debt burden, which was exacerbated by the depreciation of the Angolan Kwanza (Kz). Exports dropped by more than half, and the external accounts moved from surplus to deficit. The fiscal crisis has put human development outcomes at risk.

5. **Angola now faces the complex challenge of balancing short-term adjustment measures to address a slumping economy, against the long-term goals of improved human development outcomes.** Recent efforts have improved health and education outcomes, but Angola still trails behind comparable countries on key indicators in both sectors and the crisis is likely to have further negative effects on those outcomes jeopardizing progress made so far.

[1] World Development Indicators database at www.worldbank.org.
[2] Edstats database at www.worldbank.org.
[3] The first population census after independence took place only in 2014.

At the same time, public spending on health and education had increased up to 2013, though still below the levels of comparable countries, and has decreased since 2014. This will further constrain access to basic services and worsen education and health outcomes. In this difficult macro-fiscal context, achieving further progress on education and health indicators will require policymakers to identify and protect—or even drive to increase—expenditures in critical social sector areas, while developing new strategies to mobilize additional resources and enhancing both the allocative and technical efficiency of health and education spending.

Sectoral and Institutional Context

Health Outcomes

6. **While Angola made progress towards improving key health indicators, these remain weak compared to other middle-income countries.** Life expectancy at birth in Angola increased from 41 years in 1990 to 52 years in 2014, 5 years lower than the sub-Saharan developing countries (SSA) average, 15 years lower than the lower-middle-income countries (LMIC) average, and 22 years lower than the upper-middle-income countries (UMIC) average, despite Angola's UMIC status. Maternal mortality has also decreased from 1,160 per 100,000 live births in 1990 to 477 per 100,000 live births in 2015; a shift to now being lower than the SSA average, but double the LMIC average and 9 times the UMIC average. On the other hand, the gaps in infant and child mortality between Angola and the comparison groups' averages have either increased or narrowed only slightly. Infant mortality has declined from 134 per 1,000 live births in 1990 to 99 per 1,000 live births in 2014, declining from 109 to 58 in SSA, 83 to 41 in LMIC, and 42 to 15 in UMIC on average over the same time-period. Similarly, under-5 mortality has declined from 226 per 1,000 live births in 1990 to 157 per 1,000 live births in 2015, at an increasing absolute gap relative to the SSA and LMIC averages. It is important to highlight that initial data from the 2015-16 Multiple Indicator Cluster Survey (MICS) points to much improved infant and under-five mortality rates, in part likely reflecting different methodological approaches in calculation. Still, these rates are much higher than the UMIC average. Moreover, UNICEF recently estimated that during the 2007-2011 period, about 29 percent of under-5 children in Angola suffered from moderate-to-severe stunting (UNICEF 2013) and the 2015-2016 MICS data confirm this high rate.

Table 1. Life expectancy and mortality rates in Angola, Sub-Saharan Africa (SSA), lower-middle-income countries (LMIC), and upper-middle-income countries (UMIC), 1990-2014

	1990	2000	2010	2014
Life Expectancy at birth				
Angola	41	45	51	52
SSA	50	50	56	57
LMIC	60	63	66	67
UMIC	68	71	74	74
Infant Mortality Rate (per 1,000 live births)				
Angola	134	128	110	99 (*44*) (*)
SSA	109	94	66	58
LMIC	83	66	47	41
UMIC	42	31	18	15
Maternal Mortality Rate (per 100,000 live births)				
Angola	1,160	924	561	493
SSA	987	846	625	560

LMIC	533	410	284	257
UMIC	114	86	63	55

Source: World Bank Development Indicators database *data.worldbank.org; (*) MICS 2015-16*

7. **As of 2012-13, the top three identifiable causes of death among children under-5, as with the Angolan population as a whole, were infectious diseases, with risk factors increasing for Non Communicable Diseases (NCDs)**. Diarrheal diseases, respiratory infections, and malaria are among the top three infectious diseases affecting the Angolan population. Furthermore, despite considerable improvements over the past decade, as of 2013, Angola ranks the highest in under-5 mortality due to diarrheal diseases and acute respiratory infections (ARI) of all 194 countries with available data. In terms of under-5 mortality due to prematurity, Angola again ranks the highest of all 194 countries with available data. Of the top ten risk factors that drive the most death and disability in Angola, seven directly contribute to NCDs: air pollution, high blood pressure, dietary risks, tobacco, alcohol and drug use, high blood sugar, and high body-mass index[4].

8. **There are significant disparities in health outcomes by urban-rural location and household income level.** The under-five mortality is lower in urban areas than it is in rural areas by more than 30 deaths per 1,000 live births, and the urban infant mortality rates is lower by 7 deaths per 1,000 births.[5] There is also considerable inequality in access to prenatal care between urban and rural areas. Sixty-five percent of the rural population reported seeking a consultation when sick, versus 82 percent of the urban population. While inadequate supply of health services in poor communities and rural areas is likely to be the most important constraint to accessing health care services, factors such as public awareness of the importance of consultations and the cost of obtaining care appear to play an important role as well -- the share of out-of-pocket spending on pharmaceuticals is as high as 76 percent in rural areas due to the limited supply of drugs.

9. **There is insufficient data to adequately measure Angola's progress towards Universal Health Coverage**. However, the latest MICS shows low breadth of coverage for many health services, including family planning and contraceptive services (14 percent of the need is met), insecticide treated mosquito nets (31 percent of families have at least one), antenatal care and birth attendance (61 percent women with 4+ ANC visits, 50 percent skilled birth attendance), immunizations (31 percent children receiving complete vaccination), and HIV testing (20 percent among men and 30 percent among women in the last 12 months) (MICS 2015/16). Furthermore, the scope of services covered by primary health care posts and centers is limited and centered largely on infectious diseases (such as the highly prevalent malaria), antenatal care and birth attendance, and injuries. Lastly, although primary health care services are provided free of cost to the users, out-of-pocket expenditures correspond to 24 percent of the total expenditure on health.

Key institutional characteristics and constraints

10. **As further documented in the recent Angola Public Expenditure Review, Angola's pattern of health spending (both total and public) compares unfavorably with countries at the same or lower income level.** Public spending in the health sector increased almost four times between 2000 and 2013. However, the trend shifted downwards after spending cuts in 2014 and 2015 resulted in a real reduction of 19 and 39 percent, respectively. Health expenditures, as a percentage of the country's GDP, also declined, from 2.6 percent in 2013 to 1.5 percent in 2015. Government health expenditures are among the lowest of UMIC countries; they represented 5

[4] Top 10 causes of DALYs with key risk factors, 2015. Institute for Health Metrics and Evaluation (IHME).
[5] MICS data

percent of all government spending in 2014. For both total and public spending, Angola has consistently spent less on health than other LMICs and UMICs since 2007, and this gap grew significantly between 2009 and 2012. In terms of public spending in 2013, Angola spent about 2.6 percent of GDP on health, while Botswana, South Africa, and Namibia spent 3.1, 4.3, and 4.7 percent of GDP, respectively. Outside SSA, Angola spends significantly less than Bolivia, Ecuador, and Colombia (the gap is even bigger for Mexico and Malaysia). At roughly 60 percent, Angola's share of public spending on health as a proportion of total health expenditures between 2000 and 2014 was similar or higher than most comparators. However, the government allocates a very small share of its budget (less than 5 percent, on average, between 2005 and 2014) to the health sector, which explains the country's comparatively low levels of public health spending.

Table 2. Healthcare expenditure in Angola, Sub-Saharan Africa (SSA), lower-middle-income countries (LMIC), and upper-middle-income countries (UMIC), 1995-2014

	1995	2000	2005	2010	2014
Total Health Expenditure per capita (current US$)					
Angola	18	17	65	132	179
SSA	40	33	57	88	98
LMIC	48	58	96	198	265
UMIC	88	112	175	379	518
Total Health Expenditure per capita (% of GDP)					
Angola	6.5	2.8	4.1	3.4	3.3
SSA	6.1	5.5	5.8	5.8	5.5
LMIC	4.7	4.9	5.3	5.6	5.8
UMIC	5.2	5.5	5.6	6.0	6.2
Public Health Expenditure (% of government expenditure)					
Angola	5.2	2.8	6.1	5.4	5
SSA	-	-	11.6	11.8	-
LMIC	-	-	-	-	-
UMIC	-	-	-	-	-
Out-of-pocket Health Expenditure (% of total expenditure on health)					
Angola	20	22	39	28	24
SSA	35	30	31	31	34
LMIC	42	46	43	38	36
UMIC	51	48	49	54	55

Source: World Bank Development Indicators database *data.worldbank.org*

11. **In the immediate aftermath of the war, the country embarked on a process of deconcentration and administrative decentralization of the public health system (*Sistema Nacional de Saúde*, SNS).** The SNS encompasses the Ministry of Health (MoH), Provincial Governments with its Provincial Health Directions and Provincial Hospitals, and Municipal Administrations including Municipal Health Directions, Municipal Hospitals and Health Care Units and Posts. The MoH develops health policies, as well as prepares, evaluates and monitors annual strategic plans, and promulgates regulations. Provincial governments manage the provinces' network of health services, ensuring that all units operate within their allocated provincial budgets. Municipal governments increasingly manage the primary health care network and all basic health care activities. However, the limited administrative and technical capacity at the local level remains a constraint to tackle the challenges imposed by the decentralization process.

12. **Public health service in Angola is delivered through a 3-level pyramidal system that suffers from disrepair and overloading.** The first level consists of health centers and posts, municipal hospitals, nursing stations and doctors' offices; the second level consists of general and monovalent hospitals; and the tertiary level consists of central hospitals and specialized hospitals (Decree No. 262/10 of November 24, 2010). There are about 3,023 public health facilities within the national health system: 12 national hospitals, 46 provincial hospitals, 145 municipal hospitals, 700 health centers and 2,120 health posts (MoH PND, 2016). The public health delivery system also includes the armed forces, the Ministry of Interior and other public corporations' health facilities. The ratio of health facilities to population was estimated at 0.5 per 10,000 people in 2010, with disparities between urban and rural areas: 24 percent of the rural population had access to a public health center or clinic within a 2km radius, compared to 63 percent of the urban population. About 79 percent of current public health facilities are functional.[6] Primary health care facilities in particular are in an advanced state of disrepair and poorly-equipped with many lacking proper connection to water, electricity, and sanitation pipelines and networks, with more than half without drinking water, and 22 percent still under construction. Hence, Angolans tend to go straight to provincial hospitals bypassing the primary level, which causes overloading at the provincial level. Referral and counter-referral mechanisms between levels are not operative. Provincial hospitals lack a systematic relation with municipalities or provincial health centers, and provincial health centers in turn lack a systematic relation with municipal health centers. Private sector health providers include both for-profit and not-for-profit entities. For-profit providers serve large urban centers and their peripheries where the public health network is limited. Private not-for-profit entities, such as religious and other non-governmental organizations, service the outskirts of cities and rural areas, and serve primarily poor and disadvantaged communities.[7] Private facilities tend to be small and under-funded. Private health insurance must be purchased out-of-pocket and accounts for less than 0.5 percent of total health spending.[8]

13. **The service delivery failures are symptomatic of broader issues on how the decentralization of health care is taking place in Angola and highlights the need for more effective and efficient primary health care service delivery.** While municipal directors are involved in developing, implementing and supervising annual health plans, limited communication with the MOH constrains more informed technical decisions at the local level. Spending execution at the municipal level is high but spending does not always go for the intended purposes: health posts and municipal hospitals are not necessarily functional, health care professionals' classifications are outdated complicating effective deployment across health centers, and delays and absenteeism of staff are frequent with a lack of mechanisms to sanction poor performance. This raises the issue of how to incentivize more effective and efficient service delivery, including the most appropriate financing mechanisms. Currently, there is a lack of accountability in how funds are transferred directly from the MoF to the provinces and municipal directorates as they are not linked to national objectives or performance. This points to the need not only for more spending in primary health care, particularly maternal and child care, but also for spending which can trigger better quality and results.

14. **The lack of accountability and coordination mechanisms between central and local authorities in formulating the health budget hinders the ability to address deficiencies across different levels of the health system.** Angola has a single consolidated budget for central and local levels of governments. The General State Budget (*Orçamento Geral do Estado*, OGE) comprises the budget for central government agencies, such as the MoH, as well as the budget for all provincial governments. According to the Budget Framework Law and the Law on Local Governments, provincial governments are responsible for several public services, such as health, which includes

[6] Based on the results of a national health network mapping exercise conducted between 2007 and 2011.
[7] There are over 3,300 registered private facilities, over 60 percent in the Luanda Province
[8] WHO national health account estimates 2008-2013.

the construction and maintenance of provincial hospitals and health centers. The budget process involves the provincial governments submitting budget proposals from the provincial directorates of health and education (*Delegação Provincial de Ensino e de Saúde*) to the Ministry of Finance (MoF). The MoH also submits its own budget proposal to the MoF which includes the functioning of its support operation and policy departments, and financing of the services for which they are directly responsible including the construction and maintenance of regional and national hospitals. There is very little coordination between local and central levels when defining priorities, and in turn, formulating budgets. Instead, the MoF sets initial expenditure limits for both local and central budget proposals, and consolidates all budget submissions. At the provincial level, provincial governments allocate relevant budgets to hospitals, health centers, and municipal administrations resulting in the hospitals and municipal administrations becoming budget holders in their own right, responsible for executing their own budgets. In the end, the provincial and municipal level have complete autonomy over health services under their responsibility; however, the lack of coordination results in a missed opportunity for agreeing on shared priorities to be addressed across the national health system.

15. **Quality issues undermine the Angola health sector leading to significant impacts on health care outcomes, particularly for poor communities and rural areas.** The lack of national protocols combined with the limited technical capacity at the local level results in the ineffective use of the referral pathways across the levels of the health system. Quality is further hampered by the very limited supply of trained health staff, with the number of doctors and nurses per capita declining, and about 85 percent of doctors concentrated in regional and general hospitals in Luanda and the provincial capitals. Furthermore, an inadequate and uneven supply of healthcare training programs diminishes the effectiveness of the healthcare system. Births attended by skilled healthcare workers rose from about 25 percent in 2001 to about 50 percent in 2008; however, no further progress has been made since then. The urban/rural disparity is also reflected in this area with 2015 figures showing that about 75 percent of births in urban areas were attended by a skilled professional, compared to just 25 percent rate in rural areas (a disparity that has remained broadly unchanged since 2008).[9] Pharmaceutical quality is also an issue as there is no rigorous testing mechanism. Angola has no national quality-control laboratory. The 10 mini-laboratories introduced in 2012 to screen the quality of medicines at entry points are insufficient to cover the entire supply of imported pharmaceuticals, resulting in some products being sent to laboratories in Portugal and Brazil. Although the precise reach of the counterfeit-medicine market in Angola is unknown, a 2005 USAID report estimated that 70 percent of drugs were purchased in informal markets and that 35 percent of these purchases consisted of counterfeit drugs.[10] Finally, storage conditions are often inadequate, especially for products requiring temperature control.

16. **The lack of a results focus across the health sector leads to inefficient approaches to tackle these challenges.** Healthcare workers, as part of the civil service, receive a base salary and may qualify for bonuses, allowances and hazard pay, as well as overtime compensation. However, no wage incentives are linked to performance measures, either in terms of outputs or service quality. Although spending execution at the municipal level is high, it does not always go for the intended purposes. Health posts and municipal hospitals are not fully functional, health care professionals' classifications are outdated, complicating effective deployment across health centers, with recurring delays and absenteeism of staff. This raises the issue of how to incentivize more effective and efficient service delivery, and the most appropriate financing mechanisms to resolve some of these issues.

[9] MICS 2015-16 and Inquérito Integrado Sobre o Bem-Estar da População (IBEP) 2008/09.
[10] In September 2015 the Criminal Investigation Service (*Serviço de Investigação Criminal*) apprehended over 11,000 kg of counterfeit medications, including antibiotics, anti-malarial medications, analgesics, TB medications, and steroids.

17. **Angola's health system is further strained by its vulnerability to effectively manage public health outbreaks.** Between 2013 and 2016, the country's epidemiologic surveillance system detected five epidemics, namely: yellow fever (888 cases), malaria (3,254,270 cases), measles (27,259 cases), rabies (230 cases), and cholera (6,655 cases) (Plano Nacional de Desenvolvimento, PND 2018-2022). These occurrences highlight not only the country's vulnerability, but also weak vaccination coverage (30.6 percent complete vaccination among children 12-23 months of age according to the 2015-16 MICS. In 2016, Angola faced a yellow fever outbreak that killed at least 400 people. The outbreak erupted in December 2016 in the slums of the capital Luanda, spreading to 16 of Angola's 18 provinces and into neighboring Democratic Republic of Congo. In addition, since December 2016, a new cholera outbreak in the provinces of Zaire, Cabinda, and Benguela resulted in 150 confirmed cholera cases, 10 of which resulted in deaths.

Reform agenda

18. **In recognizing these challenges , the government has embarked on reforms to address the inefficiencies of the health system with the aim of improving health outcomes.** These challenges are highlighted in the World Bank's 2017 Public Expenditure Review, and addressed in the government's National Health Plan (*Plano Nacional de Desenvolvimento Sanitário* 2012-2025, PNDS). The PNDS, which constitutes a policy and planning framework for executing the National Health Policy (presidential decree 262/2010), recognized the need to address issues such as life expectancy at birth, and maternal, infant and child mortality. Indeed, the first National Development Plan (*Plano Nacional de Desenvolvimento* 2012-2017, PND) reflected this focus of working towards meeting the Millenium Development Goals , through improvements to primary health care, maternal and child health, and vaccination coverage in many of the specific objectives and indicators proposed in the plan. In the context of Angola's improvements in some of those areas, the recent health sector's contribution to the National Development Plan (*Plano Nacional de Desenvolvimento* 2018-2022, PND) emphasizes the need to strengthen the national capacity and management of the SNS, recognizing the instrumental role of the MoH in the governance of the decentralized health service delivery system. The PND 2018-2022 includes a national health sector reform program divided into several key priorities: Management of the National Health System; Health Regulation; Planning, Management, and Development of Human Resources for Health; Development of Health Research and of the National Laboratory Network; and Strengthening the Health Information System. The overarching objective of the reform is to strengthen the capacity and performance of the SNS with the goal of improving the health of the population, raising life expectancy, and promoting a more active popular participation in the national economic and social development process.

World Bank engagement in Angola's health sector

19. **The HIV/AIDS, Malaria and TB Control Project** (HAMSET, P083180) was a US$13.26 million project (approved in 2004 and closed in 2011), which aimed to reduce the spread of HIV/AIDS in the Angolan population, strengthen the capacity of the health sector to detect and treat TB, and strengthen the capacity of the MOH for effective case management of malaria. Lessons learned from the HAMSET project highlight the importance of engaging the government in the extensive analytical work and project preparation efforts required as part of a new project design which helps to ensure that institutional changes and the sustainability of investments are more likely with th strong government ownership. In addition, despite the importance of addressing HIV/AIDS, TB, and malaria directly through a vertical-disease focused project like HAMSET, the poor maternal and child health indicators in Angola justify the need for a broader intervention supporting the health system with specific maternal and child health interventions.

20. **The Municipal Health Services Strengthening Project** (PRSMS, P111840) is a US$70.8 million project (approved in 2010 and ongoing to 2018), which aims to improve the population's utilization of maternal and child healthcare services. Following an initial lag in effectiveness and implementation, the project supported key achievements in service delivery, notably in the areas of immunization and antenatal care at the provincial and municipal levels, as well as training of health personnel in obstetric and neonatal emergencies, integrated management of childhood illnesses, and monitoring and evaluation. The PRSMS targeted 18 municipalities in six of Angola's 18 provinces (namely Luanda, Bengo, Malange, Lunda Norte, Moxico and Uige), with an estimated 2.1 million target population. In the six target provinces, there was a marked increase in health care service delivery at the primary health care level, as evidenced by an increase in skilled birth attendance from 46 percent in 2012 to 63 percent in 2015, and coverage of approximately 530 thousand children with three doses of the pentavalent vaccine (DPT-HepB-Hib) from 2012 to 2016. The Project includes capacity building and training activities for over two thousand health personnel in skills such as emergency neonatal and obstetric care, integrated management of childhood illnesses, management and monitoring and evaluation.

Relationship to CPF

21. **Enhancing the quality of service delivery to improve the quality of life of the population is one of the two pillars in the Country Partnership Strategy (CPS) FY14-16**. The CPS supports institutional reforms and investments to create conditions favorable to improving health indicators, especially regarding child and maternal mortality. Strengthening of the health sector, through measures to improve the quality of care across Angolan's health system, is considered important to ensuring the delivery of quality health services at the provincial and municipal level. This is in line with the twin goals and the adoption of strategies aimed to boost shared prosperity. The project is also in line with the Health, Nutrition, and Population (HNP) goal of ensuring Universal Health Coverage (UHC), specifically by focusing on one of the 3 HNP priority directions of service coverage. The draft Performance and Learning Review (PLR) envisions an extension of the CPS until FY18 and a reformulation of the objectives to respond to the macroeconomic challenges emerging from the oil price drop. The draft Performance and Learning Review includes the need for increasing the efficiency of social programs as one of the key objectives.

22. **This project will also build synergies with other donor-financed projects supporting the health sector in Angola.** The proposed project would build on the Projecto de Apoio ao Sector da Saúde *(*PASS II) financed by the European Union (EU) for US$34 million across the 2013 to 2019 period. PASS II has supported the development of normative instruments to strengthen the regulatory capacity of the MoH to ensure a level of quality across the health system and the development of provincial health plans for the provinces of Huambo, Bié, Benguela, Huíla and Luanda. The proposed project would be in a position to scale up activities supported in the PASS target provinces to additional provinces supported through Bank-financing and advance the work in the area of legal norms and regulatory capacity for the MoH. Furthermore, the proposed project would build on current and ongoing health sector support being provided by USAID. A December 2016 to June 2017 Memorandum of Understanding (MoU) between USAID and the Government of Angola for the malaria program contains specific commitments on commodities, staffing, data sharing, and partner facilitation. USAID is also supporting supply chain strengthening through a partnership with Chemonics and providing US$63 million over the next five years through its flagship bilateral program "Health for All" (*Saúde para Todos*) which supports community and facility-based malaria, HIV/AIDS, family planning and reproductive health services, and capacity building through collaborative partnership with municipal and provincial authorities. The proposed project will seek to develop further direct synergies with *Saúde para Todos* to ensure the strengthening of quality measures in support of a reliable supply of essential medicines and supplies to health facilities at the municipal level.

23. **The proposed project directly supports the Government's National Development Plan (PND) 2013-2017, in increasing access to essential social services for the rural areas and the most vulnerable population**. The PND underscores the role of the health sector in ensuring quality health services are available and delivered at the municipal health facility level. The project also contributes to the objectives of Angola's health sector contributions to the 2018-2022 PND, which seeks to reinforce the capacity and performance of the National Health System with a view to improving the health of the population and their engagement in the economic and social development process of the country.

24. **The proposed project will support actions to help address the gender gaps in health services delivered in Angola by focusing on the delivery of maternal and child health services.** Health outcome indicators for Angola underscore the need to improve the quality of health services reaching women. Despite maternal mortality having decreased from 1990 to 2015 from 1,160 to 477 per 100,000 live births, respectively, Angola's maternal mortality is still two times that of the LMIC average and nine times the UMIC average. Only 61 percent of pregnant women receive four ante-natal care visits and only 50 percent of births are attended by skilled providers. This is exacerbated in the rural provincial and municipal levels where only 25 percent of births are attended by a skilled professional compared to 75 percent in urban areas.

C. Proposed Development Objective(s)

Note to Task Teams: The PDO has been pre-populated from the datasheet for the first time for your convenience. Please keep it up to date whenever it is changed in the datasheet.

The Project Development Objective (PDO) is to increase the utilization and the quality of health care services in target provinces and municipalities.

Key Results (From PCN)

The following key results would be supported through the project:

- Number of children under 5 years of age fully immunized (number)
- Number of pregnant women receiving at least four antenatal care visits (number)
- Number of birth deliveries attended by skilled health personnel (number)
- Women and children receiving basic nutrition services (number)
- Number of health facilities achieving a quality score of 75 percent (number)

These are potential key results indicators, including PDO indicators and intermediate outcome indicators that will be refined during project preparation. The Project Appraisal Document (PAD) will include a detailed description of the indicators at different levels.

D. Concept Description

25. The project intervention areas are defined according to two basic criteria: ability to improve access and quality of basic health care services, and alignment with the government's priority health sector reform agenda. The proposed project would maintain the service delivery coverage under the Municipal Health Services

Strengthening Project (P111840), which focused on six provinces and 18 municipalities[11], and would assess covering additional provinces and municipalities. The selection of additional potential provinces and municipalities will be based on the first six of the seven criteria used under the government's Revitalização Program which began in 2016 and aimed to improve the supply and quality of health services, increase access, and thus equity. These six criteria include: (i) population to be reached, (ii) health status, (iii) accessibility, (iv) availability of infrastructure, (v) inclusion in the decentralization program, and (vi) availability of staff, drugs, and supplies[12]. The health sector diagnostic re-affirmed the challenge areas to be addressed through the reforms. These include: the rural/urban disparities, reflecting a lack of access and quality of health services that is more pronounced at the local level; the weakened national health system with a limited coordination role played by the MoH in management and financing decisions; and the vulnerability to public health outbreaks that spread rapidly from populated urban centers to the more remote rural areas. Given these key constraints, the project would focus on three main interventions: (a) supporting the delivery of quality primary health services in the target provinces; (b) supporting activities related to the strengthening of the national health system that have a direct impact on the delivery of quality health service delivery across the country; and (c) providing flexibility to address potential public health outbreaks. The proposed project would implement a Results-Based Financing (RBF) scheme as part of the delivery of health services in two[13] of the target provinces.

26. **Component 1 – Improving the Quality of Health Services Delivery in Target Provinces (US$65.0 million).** This component would support activities at the provincial and municipal level to improve the quality of the health care services in the target provinces and municipalities with the development of an RBF pilot in two selected provinces (US$10.0 million).

27. Subcomponent 1.1. Improving the Quality of Maternal and Child Health Services at the Provincial and Municipal Level. This subcomponent will focus on improving the quality of maternal and child health services delivered at the provincial and municipal level. The criteria to be used for the selection of target provinces will be based on (i) the provinces and municipalities covered under the current Municipal Health Services Strengthening Project (PRSMS-P111840), and (ii) additional provinces and municipalities based on the six criteria of the Revitalização Program. This subcomponent will continue to finance the delivery of health services currently supported under the PRSMS project which includes: (i) a small grant allocation for inputs such as equipment, supplies, and mobile health team visits, and (ii) capacity building for provincial and municipal health workers to better manage, supervise, and provide quality control of maternal and child health services provided at different levels of health care, based on norms and guidelines. To complement service delivery, this subcomponent will also support key actions to strengthen local governance of the health system by: (i) incentivizing managers to maintain and implement health system maps *(mapas sanitários)* in the targeted provinces and municipalities, (ii) developing an enabling environment for the implementation of hospital waste management system in additional target provinces of the project, duplicating the national plans for management of environmental and hospital waste for the Province of Luanda. , and (iii) review of existing citizen engagement mechanisms such as the RBF community based survey tool to define an approach that helps clients provide feedback which in turn can be used to improve services.

[11] Bengo, Luanda, Lunda Norte, Malanje, Moxico, Uige – e 18 municípios - Dande/Caxito, Ambriz, Icolo&Bengo, Lucapa, Cambulo, Cuango, Chitato, Malanje, Cacusso, Calandula, Caculame, Moxico, Luena, Cmanongue, Uige, Maquela de Zombo, Negaje, Sanza Pombo

[12] The seventh criteria indicating the presence of UNICEF and WHO will not be required to not limit the potential collaboration across agencies.

[13] The two provinces initially identified for the RBF scheme are Huila and Lunda Norte

28. Subcomponent 1.2. Piloting Results-Based Financing (US$10.0 million). The Results Based Financing (RBF) pilot will support health service delivery through a performance focus adjusted for the provincial and municipal level context. Angola has not had any previous experience implementing RBF. This Concept Note proposes to move forward with an assessment to design an RBF scheme to include, but not limited to, the identification of the beneficiary population, the services (interventions) to be incentivized, the data sources for monitoring and verification of results, and funding flows, while keeping an eye to the benefits of RBF for overall health system strengthening. As part of project preparation, the task team will review the basic package of health services supported by the Angola MoH, select key interventions to be incentivized in line with the maternal and child health focus, and cost the intervention using existing costing information and further Bank analysis. In parallel, the Bank team will work with the Social Protection project and the Ministério da Administração do Território (MAT) to use existing social registries in support of the identification and registration of the beneficiary population. The overall objective of the RBF scheme in Angola will be to introduce contracting mechanisms using the existing flow of funds structure in place in the country (where the MoF directly transfers financial resources to the MoH, the province, the provincial hospitals, and the municipal administration). The contracting scheme will focus on the MoF transfer to the province and municipality and proposes to set aside a percentage of the transfer to be used for the payment for performance at different levels of the health system. This percentage will be paid based upon the achievement of targets in the interventions selected to be incentivized. As part of the contracting scheme, contract management skills will need to be developed and strengthened in both ministries. The MoH will work with the MoF to: (i) develop and manage the contracts are to be entered into by the provinces/municipalities documenting the targets to be achieved across the selected intervention areas; (ii) define the reporting periodicity and sources of information for assessing the achievement of the targets; (iii) review the results reported and confirm the achievement or not; and (iv) provide MoF with the validated results against which payment can be made. The RBF pilot aims at : (i) demonstrating that the contracting mechanism creates the enable environment for positive behavior change for health workers which leads to increased productivity in quantity and quality of services); and (ii) identifying and supporting the institutional changes needed for the contracting mechanism to be developed within the framework of the national budget in order to reduce inefficiencies in spending and increase financial accountability of actors at different levels of the health care system. The MoH requested that the RBF scheme be rolled out in two provinces: Huila and Lunda Norte. These were selected as representing on one hand a province that currently has strong health outcomes, and another that is challenged in producing good health outcomes. Health facilities in these target provinces will be provided with essential equipment to ensure there is a common baseline level of primary health care services with a basic functional set-up.

29. **Component 2 – Strengthening the Stewardship of the National Health System to Support Delivery of Quality Health Services (US$25.0 million).** This component aims to support institutional strengthening across the national health system towards improving the quality and coordination of health care services delivered at the municipal, provincial, and national levels. The component will therefore contribute to reducing health system inefficiencies -- a critical effort given the country's limited availability of resources. Activities in Component 2 will support the strengthening of data collection and use for improved evidence-based decision-making, the implementation of normative instruments and regulations for the health sector, and the updating and development of national policies and plans for human resources for health. Component 2 will also support the broader reform agenda of the MoH to address system bottlenecks to improve health outcomes. The component will assist the sector for improved coordination and stewardship of the sector for effective and quality frontline service delivery.

30. **Accordingly, Component 2 will provide support to the national MoH to:** (i) build capacity in the production and management of a health workforce to increase the availability of providers at the local levels; (ii) strengthen national capacity to detect and respond to public health outbreaks; (iii) support the development of reliable data and health intelligence, from the national School of Public Health, national surveys (DHS and SDI surveys), and strengthening of monitoring and evaluation capacity; (iv) improve pharmacosurveillance and regulation of the pharmaceutical sector; and (v) support improvements to the flow of funds that finance the health system, shifting from an input-based to a results-based approach. In particular, this subcomponent will support strengthening of governance structures in the MoH in the area of procurement (including strategic procurement as part of Public Financial Management).

31. **Component 3 – Supporting the Capacity to Respond and Prevent Public Health Emergencies (US$0).** The component will provide surge funding to finance response efforts directed at preventing an outbreak from becoming a deadly and costly pandemic. The component will only be triggered in the case of a public health emergency and when certain actions, as agreed by the Government and Bank teams, are met. These actions can include the following: (i) the country declares a national public health emergency; and (ii) presents a sound and actionable country-level response plan. This component provides a platform for country-level discussions on the importance and need for country-level readiness to respond to disease outbreaks. Once triggered, the component will be guided by Operational Policy OP10.00, Paragraph 12, which enables rapid reallocation of funds between project components following an emergency. Together with the operational, fiduciary, procurement, disbursement and financial management arrangements that underpin its implementation, the component provides a conduit for additional emergency funds into the project.

32. **Component 4 – Project Management and Monitoring and Evaluation (US$10M).** This component supports project implementation by the MoH, including project management, fiduciary tasks and Monitoring and Evaluation (M&E).

Note to Task Teams: The following sections are system generated and can only be edited online in the Portal.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

As per initial discussions, the Government would like the project to continue to focus on the six provinces targeted under the current Municipal Health Services Strengthening Project (P111840) which include, Bengo, Lunda Norte, Luanda, Malanje, Moxico, and Uige, however, would like to scale up the number of municipalities reached from 18 under the current Project.

B. Borrower's Institutional Capacity for Safeguard Policies

The Bank's safeguards specialists have been assessing the borrower capacity under the ongoing Municipal Health Service Strengthening Project ((P111840). Initially, the PIUs did not have any E&S Safeguards specialist supporting the project as required which translated in the poor safeguards performance recorded in project's ISRs. After a Bank mission in July 28, 2016, the borrower and the Bank have set up an action plan to strengthen the PIU Capacity to handle project's safeguards

requirements which included: i) assignment of a dedicated E&S safeguards focal point; ii) a series of training on safeguards, particularly on issues related to Biosafety and Health Waste Management; production of information materials to further disseminate the importance of safeguards in Health projects.
During the July 2016 mission the Bank team was pleased to see high level ownership and commitment to the safeguards aspects from the borrower which contributed to the satisfactory follow up of key recommendations agreed from the previous mission. Evidence has since shown that a safeguards focal point was assigned in the PIU and organized a series of training to 30 technicians from 6 provinces (Bengo, Malange, Lunda Norte, Moxico, Uige and Luanda) and 18 municipalities from these same provinces. Prior to the trainings the Bank reviewed the proposed training programs and the profile of the facilitators which had international certification and extensive experience in Biosafety and Environmental, Health Waste Management issues . With the support from the Bank, borrower also prepared and approved Operational Manual for Health Waste Management which will also serve as the basis to propose mitigations measures of the current project. Despite those improvements in safeguards handling, there are still challenges that need to be addressed, particularly in the allocation of dedicated budget and resources for further safeguards capacity, particularly for subprojects screening, monitoring and reporting. This projects will make budget provisions to further improve borrower safeguards capacity both at local and central levels

C. Environmental and Social Safeguards Specialists on the Team

Kristyna Bishop, Paulo Jorge Temba Sithoe, Mario Rizzolio, Nadia Henriqueta Gabriel Tembe Bilale

D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	OP 4.01 is triggered as a result of the anticipated environmental and social adverse impacts associated with the proposed activities under component 1 aimed at improving the quality of the health care services in the target provinces and municipalities which triggers concerns about healthcare waste management and the constructions infrastructures. A current assessment has indicated that health care waste and contaminated health care waste handling, storage and disposal, in particular are weak. Health workers, waste handlers, users of health facilities and the general public are all exposed to health care related waste and may become infected, as a result of poor management. Under the Municipal Health Service Strengthening Project ((P111840) the government developed a national Health Care Waste Management Plan (HCWMP) which under implementation and will be subject to adjustments to address this project's specific requirements. The HCWMP will include detailed budget provisions for mitigation measures and capacity building, and their timely monitoring.

Natural Habitats OP/BP 4.04	No	The project will not support any actions that would significantly convert or degrade natural habitats.
Forests OP/BP 4.36	No	The project will not affect forest areas.
Pest Management OP 4.09	No	The project will not affect activities related to pest management.
Physical Cultural Resources OP/BP 4.11	No	The project will not affect any of the country's physical cultural resources.
Indigenous Peoples OP/BP 4.10	TBD	San indigenous peoples meeting the four criteria live in at least 2 of the provinces in which the project will be implemented (Huila and Moxico). During preparation and before appraisal, the Borrower will conduct a social assessment to confirm the presence of indigenous peoples and will prepare an IPP to provide guidance for the implementation of activities under Component 1 and 2. This guidance will include screening criteria, information regarding culturally appropriate participation/consultation and adaptations to ensure that indigenous peoples will benefit from the improvements in health care services and delivery.
Involuntary Resettlement OP/BP 4.12	No	Project financed activities are focused on strategic planning and improving access to services already offered by the health care system. There will not be any physical investments and therefore project activities will not require any land acquisition or cause any negative impacts on livelihoods.
Safety of Dams OP/BP 4.37	No	Dams will not be affected under the project.
Projects on International Waterways OP/BP 7.50	No	The project will not take place on international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The project will not be implemented in disputed areas.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Nov 16, 2017

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

The time-frame for launching and completing the safeguard-related studies that may be needed is to take place during the project preparation stage of the project.

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APPROVAL

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