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

Appraisal Stage | Date Prepared/Updated: 18-Dec-2017 | Report No: PIDISDSA23143

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Angola	P160948	Angola Health System Performance Strengthening Project (HSPSP)	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
AFRICA	15-Dec-2017	22-Mar-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.

Components

Improving the Quality of Health Services Delivery in Target Provinces
Strengthening System-wide Enabling Factors that Support Delivery of Quality Health Services
Contingent Emergency Response Component (CERC)
Project Management and Monitoring and Evaluation

Financing (in USD Million)

Financing Source	Amount
International Bank for Reconstruction and Development	110.00
Total Project Cost	**110.00**

Environmental Assessment Category

B - Partial Assessment

Decision

The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and 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.** Angola experienced one of the bloodiest and prolonged conflicts in Africa. It began with the fight with the Portuguese colonial power in 1961 and continued as a civil war for almost thirty years after independence in 1975, ending only 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 social fabric. The country was subsequently left without a functioning health-care system (its infant and child mortality rates were and still are worse than those for comparable countries[1]), with some of the lowest primary school enrollment rates [gross and net] when compared to Sub-Saharan Africa (SSA) and Lower Middle 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 experienced rapid economic growth due to oil resources over the last decade.** Angola is one of the largest countries in SSA and the region's second largest oil producer. The rise of the oil sector has driven a steady increase in GDP per capita. Between 2004 and 2014, the Angolan economy expanded at an annual average rate of 7.9 percent. This economic growth was mirrored by the population growth. In 2000, Angola's population was 16.44 million and by 2014, the population had risen to 26.9 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.

3. **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.

4. **Angola now faces the complex challenge of balancing short-term adjustment measures to address a slumping economy, against the long-term goals of improving 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. At the same time, public spending on social sectors, such as health and education, that had increased up to 2013, though still below the levels of comparable countries, have decreased since 2014. This will further constrain access to basic services and worsen the country's already poor social outcomes, as discussed below. In this difficult macro-fiscal context, achieving further progress on social indicators will require policymakers to identify and protect—or even increase—expenditures in

[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.

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.

Social and Health Outcomes

5. **The benefits of the burgeoning oil sector have not been felt across the population, as poverty remains widespread and Angola's social indicators are not compatible with its per capita income of US$3,630.7** (2017, estimate)[4]**.** The conflict triggered massive migration from rural to urban areas and exacerbated geographic disparities in income, opportunities, and human capital. Poverty remains widespread, 36.6 percent of the population lived below the national poverty line of US$64 per month in 2008 (58.3 percent in rural areas and 18.7 percent in urban areas, the last year for which data is available) and 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.

6. **While Angola has made progress towards improving key maternal and child health (MCH) indicators, these remain below comparators.** 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 less than the lower-middle-income countries (LMIC) average, and 22 years lower than the upper-middle-income countries (UMIC) average. 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 that now places Angola below the SSA average, but that is still almost twice the LMIC average and twelve times the UMIC average[5]. In addition, although the gap in infant and child mortality between Angola and the LMIC average has decreased (Angola's infant mortality declined from 134 per 1,000 live births in 1990 to 44 per 1,000 live births in 2015,[6] a 67 percent reduction), infant mortality remains higher than the LMIC average of 40 infant deaths per 1,000 live births. It is important to highlight that data documenting this progress comes from the 2015-16 Multiple Indicator Cluster Survey (MICS); however, given the methodological differences in estimation, these data are not strictly comparable to previous ones. Finally, MICS 2015-17 shows 38 percent of under-5 children in Angola suffered from chronic malnutrition (low height for age) and 34 percent of children ages 6-59 months have moderate or severe anemia.

7. **The low coverage of maternal and reproductive health services contributes to poor MCH outcomes.** An estimated 46 percent of births over the last two years took place in a health facility, and 50 percent of births were attended by skilled health professionals (8 percent doctors and 42 percent nurses and midwives).[7] For births occurring over the last five years, 61 percent of pregnant women attended four or more antenatal care consultations, and 56 percent of women received two or more tetanus vaccines during the last pregnancy.[8] Although most maternal deaths are known to be preventable, hemorrhage during pregnancy or childbirth, unsafe abortions, septicemia, toxemia, and uterine rupture are the leading causes

[4] IMF World Economic Outlook 2016. https://www.imf.org/external/pubs/ft/weo/2016/02/weodata/index.aspx
[5] World Development Indicators database at www.worldbank.org
[6] Instituto Nacional de Estatística (INE), Ministério da Saúde (MINSA), Ministério do Planeamento e do

Desenvolvimento Territorial (MINPLAN) e ICF. 2017. *Inquérito de Indicadores Múltiplos e de Saúde em Angola*

2015-2016 (MICS 2015-2016). Luanda, Angola e Rockville, Maryland, EUA: INE, MINSA, MINPLAN e ICF.
[7] MICS 2015-2016
[8] MICS 2015-2016

of direct obstetric deaths. Other risk factors include teenage pregnancy and the short intervals between births. 25 percent of births are spaced less than 24 months. Only 13 percent of married women or women ages 15-49 in a stable union use modern methods of contraception. Among women ages 15-49 who are unmarried or not living in a union but who are sexually active, 27 percent use a modern contraceptive method, with male condoms being used by 20 percent. In addition, gender-based violence is a complex social issue that can impact women's ability to access health care services. In Angola, 33 percent of women ages 15-49 reported having been a victim of physical or sexual violence, with the majority of those being victim to violence from a current or previous partner.[9] Of the 36 percent of victims of sexual or physical violence who seek help, only 2 percent seek assistance from a health professional.[10]

8. **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, however, risk factors associated with Non Communicable Diseases (NCDs) are becoming more important.** 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, prematurity and acute respiratory infections (ARI) of all 194 countries with available data. It is important to note that Angola might be approaching an epidemiological transition, with the more complex and costly NCDs becoming more prevalent: 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[11]. This threat represents an important challenge for the organization and financing of the Angolan health system.

9. **There are significant disparities in health outcomes by urban-rural location and household income level.** Between 2007 and 2011, significant health progress was made in rural areas, the poorest quintile, and regions other than Luanda. However, data from the 2015-16 MICS reports a malaria prevalence of about 22 percent in rural areas and 7.5 percent in urban areas. This reaffirms malaria as a continuing health problem in Angola, especially for rural communities. The under-five mortality is also 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.[12]. 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.

10. **The inadequate supply of health services and inputs, particularly medicines, in poor communities and rural areas is likely to be the most important constraint to accessing health care services.** As will be further detailed below, health facilities are unevenly distributed and generally poorly equipped, leading to a shortage of health units and services in the more remote provinces (e.g. Cuando Cubango) and rural areas. Supply-chain problems related to the procurement, storage and distribution of drugs, combined with a lack of resources, have severely impacted the availability of drugs and vaccines. For example, 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. Angola is currently facing a broad and severe shortage of tuberculostatic drugs; some parts of the country have not received rabies vaccines for the last two years, and even the availability of antimalarial

[9] MICS 2015-2016
[10] MICS 2015-2016
[11] Top 10 causes of DALYs with key risk factors, 2015. Institute for Health Metrics and Evaluation (IHME).
[12] The MICS data do not allow for this level of disaggregation.

drugs has been compromised.

Health sector financing and spending

11. **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.** Angola's pattern of health spending compares unfavorably, in almost every single criterion, with respect to almost any relevant country (or group of countries) that is used as comparator. In the past fifteen years (i.e. between 2000 and 2014), total health expenditures in Angola, whether measured in per capita terms or as a percentage of GDP, have been well below the patterns observed in comparable countries, in the world as whole, in Sub-Saharan Africa or with respect to other middle income country group averages. Health expenditure as a proportion of GDP is even lower than a much poorer country like Mozambique. The data also show that these differences have generally worsened in recent years (2010-2014), even before the significant cuts that have taken place in the last couple of years due to the economic crisis. Public spending has represented a significant (roughly 60 percent) proportion of total health expenditure in Angola between 2000 and 2014, a level that is similar or higher than most comparators, however, the government allocates a very small share of its budget (slightly less than 6 percent on average between 2000 and 2014) to the health sector, which explains the overall low levels of health spending by the country. Outside SSA, Angola spends significantly less than other mineral-rich countries such as Bolivia, Ecuador, Colombia, Mexico and Malaysia.

12. **Increases in health spending observed during the period of oil boom have been compromised by the important cuts of recent years that threaten the health gains recently achieved.** The data show that the public health sector was somewhat benefited by the economic boom and two-digit annual growth experienced by the country between 2004 and 2009, increasing to some extent its participation in the economy and in the government budget. Per capita public spending in the health sector increased more than four times in real terms between 2000 and 2013. Nevertheless, after that, as economic growth decreases, the share of public spending on health diverts to lower proportions of the GDP and of the government budget. This pattern was reinforced by cuts in public spending in 2014 and 2015, resulting in a reduction of 19 and 39 percent in the government spending in health, respectively. Data from the Ministry of Finance show that health expenditures by the public sector declined, from 2.6 percent of the country's GDP in 2013 to 1.5 percent in 2015. Spending on immunization programs fell by 50 percent from 2014 to 2015, and data from the 2015/16 MICS already suggest that vaccination rates for DTP and Polio-3 have already dropped to about 40 percent in 2015.

13. **Budget execution was strong through the expansion years, averaging close to 99 percent at the MOH and 98 percent at the provinces.**[13] At the central level, execution rates were consistently high until 2014, suggesting a higher capacity for the Ministry of Health (MOH) to spend on infrastructure (Figure 8). However, execution rates were low in 2014 and 2015, but this reflected mid-year budget cuts. Provinces appeared to be somewhat better at spending their own resources, which were based on earmarked transfers from the oil and mineral industries, but the difference was small. Provinces were generally better at spending their budgets than municipalities, likely indicative of the increasing execution responsibilities assigned to that level, but not supported with more capacity development or because of delayed release of

[13] Calculated comparing initial budget to validated spending.

funding from the provinces. Budget execution was consistently lower for capital expenditures and goods and services throughout the 2008-2014 period (Table 4).

Key institutional characteristics and constraints

14. **In the immediate aftermath of the war, the country embarked on a process of "deconcentration", which involved the administrative decentralization of the public health system (*Sistema Nacional de Saúde*, SNS).** The SNS encompasses the Ministry of Health (MOH); Provincial Governments with their Provincial Health Directions and Provincial Hospitals; and the Municipal Administrations which run the Municipal Health Directions, Municipal Hospitals and Health Care Units and Posts. The MOH is responsible for the development of health policies, the preparation, evaluation and monitoring of annual strategic plans, as well as the promulgation of regulations. The provincial governments have the responsibility of managing the provinces' network of health services, and of ensuring that all units operate within their allocated provincial budgets. Municipal governments are increasingly managing 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.

15. **Health services provided by the National Health System are free of charge and 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.[14]

16. **The lack of accountability and coordination mechanisms between central and local authorities in formulating the health budget hinders the ability to address deficiencies across the 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. Per the Budget Framework Law and the Law on Local Governments, provincial governments are responsible for several public services, such as health, which includes 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 the ministry is directly responsible, including the construction and maintenance of regional and national hospitals. There is, however, very little coordination between local and central levels when defining

[15] There are over 3,300 registered private facilities, over 60 percent in the Luanda Province

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.

Service delivery and quality-related issues

17. **The service delivery failures are symptomatic of a fundamentally dysfunctional health system, highlighting 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. These problems raise the question of how to incentivize more effective and efficient service delivery, including the most appropriate financing mechanisms. Currently, there is a lack of accountability on how funds are used by the provinces and municipal directorates, as they are transferred by the MoF without any link to national goals or to performance. While it is clear that Angola needs to spend more in health, particularly in maternal and child services at the primary level of care, the country needs to promote a type of spending that can trigger better quality of care and better health outcomes.

18. **Primary health care facilities, in particular, are in an advanced state of disrepair**. These facilities are 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.[15] 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.[16]

19. **Several quality-related issues undermine the Angola health sector, leading to significant impacts on health care outcomes, particularly for poor communities and rural areas.** As already noted, the lack of national protocols, combined with the limited technical capacity at the local level result in the ineffective use of the referral pathways across the levels of the health system. Quality is further hampered by the very

[15] There are over 3,300 registered private facilities, over 60 percent in the Luanda Province
[16] WHO national health account estimates 2008-2013.

limited supply of trained health staff: the number of doctors and nurses per capita has been declining, and about 85 percent of doctors are concentrated in regional and general hospitals in Luanda and provincial capitals. While nurses can provide primary care effectively, and community healthcare workers could supplement the health sector's limited human resources in the short run (Box 1), Angola will need to increase the number of doctors per capita in order to boost the supply of more sophisticated forms of care and meet the challenges of its impending epidemiological transition. Furthermore, an inadequate and uneven supply of training programs diminishes the effectiveness of the healthcare system (see the paragraphs that follow). Even though births attended by skilled healthcare workers rose from about 25 percent in 2001 to about 50 percent in 2008; 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 in rural areas (a disparity that has remained broadly unchanged since 2008).[17] The quality of pharmaceutical products is also an issue of concern, 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. As a result, some products have to be 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.[18] Finally, storage conditions are often inadequate, especially for products requiring temperature control.

[17] MICS 2015-16 and Inquérito Integrado Sobre o Bem-Estar da População (IBEP) 2008/09.
[18] 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.

Box 1: Community Health Workers and Health and Development Agents in Angola

The Community Health Worker (CHW) program has augmented the health sector's human resources by training personnel from local communities. The Luanda provincial government launched the CHW program in 2007. By June 2009, the program had trained 2,548 CHW, who provided services to a maximum of 261,357 families. The CHWs were selected directly from their communities, which enabled them to change local norms regarding health services. CHWs worked in close coordination with midwives to educate pregnant women on prenatal care and vaccinations. CHWs also significantly improved local data collection. The CHWs working in the districts most affected by a major cholera outbreak in 2006 were instrumental in containing the disease, especially through water treatment. By playing an active role in their communities, CHWs have enhanced the productivity of limited primary healthcare staff and facilities.

Community Health and Development Agents (*Agentes de Desenvolvimento Comunitário e Sanitário*, ADECOS) also support the delivery of health services at the community level. Like CHWs, ADECOS provide a connection between the health service network and the local community. ADECOS do not deliver health services directly, but they support the health system though public outreach. The health-specific role played by the ADECOS includes key health promotion activities such as helping refer children and pregnant women for follow-up care and consultations, promoting institutionalized births and good practices for vertical disease programs (e.g., use of mosquito nets), monitoring and collecting data on the health conditions of community members and health services delivered at the community level to the national information system. ADECOS also play an important role in helping address complex challenges that require a coordinated multi-sectoral approach such as referring women and adolescents and young people to family planning, providing guidance on the use of water for consumption through boiling or bleach, teaching proper nutrition and child stimulation practices in the critical first 1,000 day window of a child's life, and bringing services to women with restricted movement to address issues around gender-based violence. Sub-component 1.1 of the project (paragraph 32) further describes how the project will support the development of multi-sectoral coordination, through the ADECOS, for complex problems that require a multi-sectoral approach.

The Ministry of Health introduced the "mobile brigades" as part of an integrated approach to improving maternal and child health services. As with the CHW and ADECOS programs described above, and based on the experiences of other countries such as Brazil, the mobile brigades were introduced to support the existing health network in expanding maternal and child health services at the community level. Each mobile brigade comprises 5 to 8 individuals, who provide a basic package of health services to remote communities. The brigade consists of health workers, health educators, and social mobilizers. "Advanced brigades" focus on more complex health needs and include medical specialists such as obstetricians, pediatricians, and internal medicine specialists. The brigades make their services available to a community for a one- or two-day day period. Mobile brigades enable health workers to divide their time between executing their normal duties at health posts and serving remote communities.

Source: Authors

20. **An inadequate and uneven supply of healthcare workers (HCWs), together with a human resources system with limited information further diminishes the effectiveness of the healthcare system.** Training for HCWs appears to be largely focused on nurses and mid-level technicians, and there is an acute lack of training options for more specialized medical services. The government provides scholarships for Angolans to receive medical education in Cuba, but it is not clear if this is sustainable. Moreover, there is a limited pool of students with the necessary academic background to receive further training. According to a 2014 Ministry of Health study, Angola has a total of 46 health training institutes, which include Technical Health Training Schools, Superior Polytechnic Schools, and Faculties or Institutes within Universities. However, these tend to be concentrated in urban areas. Angola's ability to produce a steady supply of health workers is challenged by the lack of a needed skills-base of entering students, low salaries of teaching staff, and insufficient health professionals in the country from which to recruit faculty for hands-on clinical studies. Moreover, the human-resource management system has insufficient information on the needs and movement of workers within provinces. Though national regulations (the REGUSAP) specify the number and category of personnel required for each type of health facility, information for the "personnel matrix" (*quadro de pessoal)* is provided at the provincial level.[19] As a result, this matrix does not sufficiently reflect workers' needs at the municipal level and transfers between facilities and/or municipalities within the same province, which may leave some facilities unattended.

21. **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.

22. **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

[19] The central level determines the number of health workers recruited each year at the various levels and by type of workers based on their own analysis, the REGUSAP norms and the requests from the local level. Those requests are made using the provincial personnel tables which are not granular enough.

23. **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 were also noted 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 Millennium 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 PNDS. In the context of Angola's improvements in some of those areas, the health sector's contribution to the more recent National Development Plan (*Plano Nacional de Desenvolvimento* 2018-2022, PND 2018-2022) 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.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

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

Key Results

Indicators measuring progress towards the achievement of the PDO can be divided into two types, those measuring progress towards improvement in the utilization of MCH services, and those that measure quality of services, as outlined below.

Utilization related indicators:

- Pregnant women delivering in health facilities
- Children ages 12-23 months vaccinated against childhood diseases
- Reproductive, maternal and child health consultations conducted through Mobile brigades

Quality related indicators:

- Pregnant women receiving at least four antenatal care consultations
- Pregnant women receiving at least two doses of anti-tetanus vaccine
- Health centers presenting stock-outs of antimalarial drugs during the third quarter of the calendar year

- Municipal hospitals presenting stock-outs of first-line Tuberculosis medications within the last month

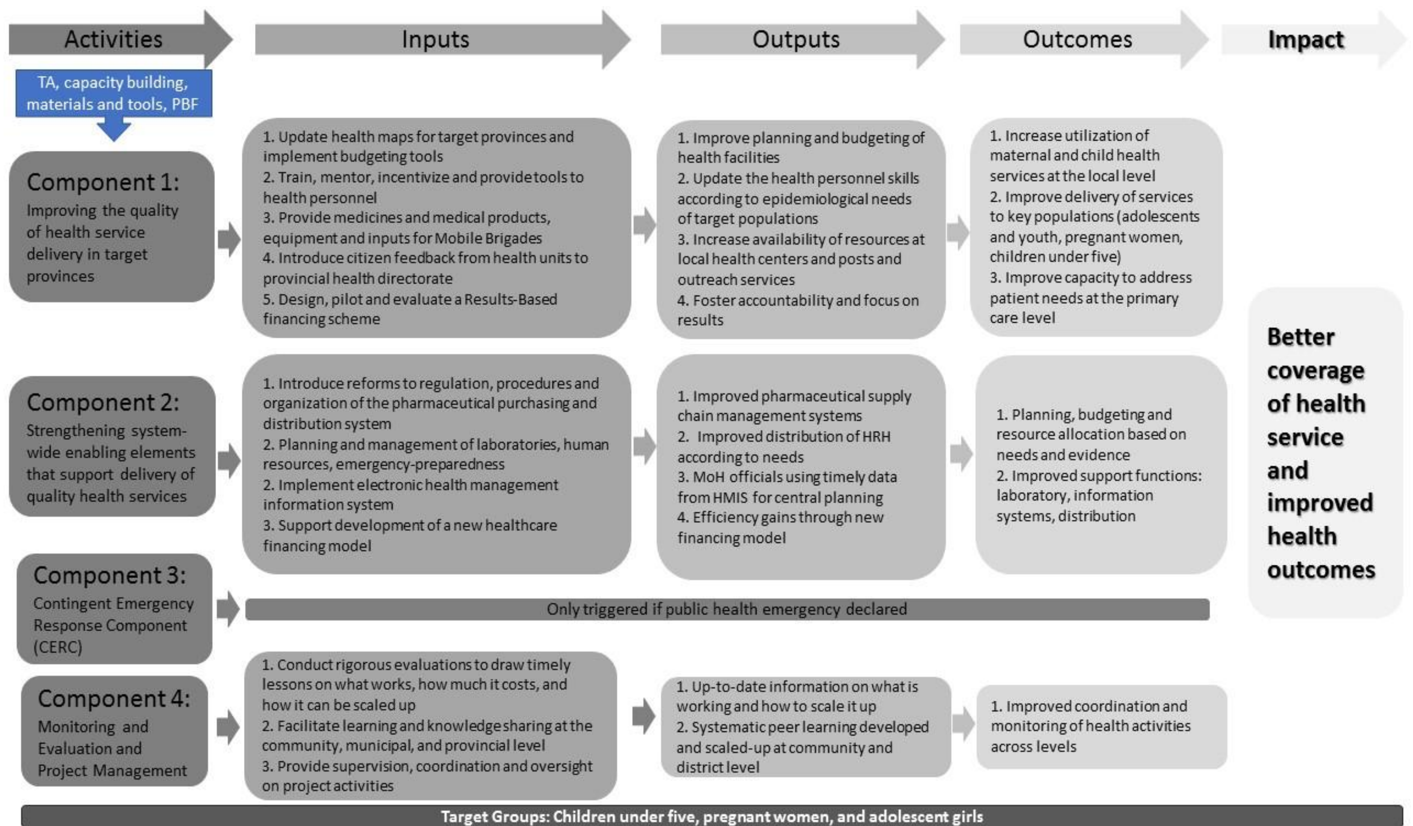
D. Project Description

24. **The project components are structured to respond to Angola's key health sector challenges as laid out in the earlier sector context and diagnostic.** In order to achieve the goals defined by its development objective, the project will support efforts that directly address the delivery and quality of health services in its intervention provinces and municipalities, as well as those "indirect" elements related to the strengthening of the national health system that are enabling factors or conditions for the provision of health services of higher quality.

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[20] and would add an additional province and three municipalities within the newly selected province. 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 two main interventions: (a) supporting the delivery of quality primary health services in the target provinces, under which a Performance-Based Financing (PBF) scheme would be piloted as part of the delivery of health services; and (b) supporting activities related to the strengthening of the national health system that create the enabling conditions for the delivery of quality health services. In addition, the project would have a third component to provide flexibility to address potential public health outbreaks and a fourth component for the project management and monitoring and evaluation functions. The figure below presents the project's theory of change for the two main components of the project as all technical activities will be implemented under these components.

[20] 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

Figure 1. Project Theory of Change



26. **The Project will work to increase the utilization and quality of a package of maternal and child health services.** This package is based on a strategy of continued care throughout key developmental stages, including infancy, childhood, adolescence, gestation, and motherhood. The continuum of reproductive, maternal and child health care supported through the project are based on several internationally recognized approaches to care, such as: Integrated Management of Childhood and Neonatal Illnesses, youth-friendly reproductive health services, healthy timing and spacing of pregnancies, prevention of mother-to-child transmission of HIV, intermittent preventive treatment of malaria during pregnancy. These strategies will serve as a basis for Project-supported health service delivery in Component 1, and will inform the strengthening of system-wide enabling elements through Component 2.

27. **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 a PBF pilot in two selected provinces.

28. Subcomponent 1.1. Improving the Quality of Maternal and Child Health Services at the Provincial and Municipal Level (US$45.0 million). This subcomponent will focus on improving the quality of maternal and child health (MCH) services delivered at the provincial and municipal level. The target provinces and municipalities were selected to maintain the coverage under the MHSS project. The selection criteria and

number of health facilities is described above in the "Project Beneficiaries" section. To help deliver the MCH services under this sub-component and help address the complexities around delivering and promoting the use and access to reproductive health services at the municipal level, the ADECOS, described earlier in Box 1, will play a key role. This project will tap into the 531 ADECOS trained under the current MHSS project. The ADECOS will draw on local, community knowledge to construct targeted messages on proper pre- and post-natal care, child vaccination, and proper child nutrition and stimulation practices. The ADECOS will also play a critical role in the area of adolescent health to reduce and prevent repeated childbearing among teenagers which will require close coordination with the education sector. The ADECOS will also coordinate with the Ministry of Social Protection to help bring services and knowledge to women in restrictive conditions due to their socio-economic state and/or being subject to violence that prohibits or limits their movement.

29. This subcomponent will continue to finance the delivery of health services currently supported under the MHSS project which includes: (i) 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 Results Based Financing (RBF) community based survey tool to define an approach that helps clients provide feedback which in turn can be used to improve services.

30. Subcomponent 1.2. Piloting Performance-Based Financing (US$20.0 million). The HSPSP will pilot a supply-side RBF approach referred to as Performance Based Financing (PBF). The PBF pilot will support health service delivery through a performance focus adjusted for the municipal context. Since Angola has not had any previous experience implementing PBF approaches, this sub-component will support south-to-south learning exchanges between Angola and other countries on a global level with practical experiences to share. An assessment due to commence in December will inform the PBF design in areas 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 PBF 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 and the inputs for those being developed to support the identification and registration of the beneficiary population.

31. The PBF scheme in Angola will 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 municipality and will assess the possibility of setting aside a percentage of the transfer, and

introducing a top-off through the project, to be used for the payment for performance at different levels of the health system. This percentage could be paid based upon the achievement of targets in the interventions selected to be incentivized. The MOH will work with the MoF to: (i) develop and manage the contracts that 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.

32. As per discussion with the MOH, the PBF scheme will be piloted in four municipalities, from two different provinces, that will be determined based upon the inputs to be received from the design assessment. 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.

33. The PBF pilot will be implemented in a phased manner.
    - Year 1 (2017) will be dedicated to preparatory activities such as the PBF manual, training on PBF techniques, hiring consultants, preparing PBF contracts, Information Technology (IT) processes, contracting with the potential verification bodies, and engaging NGOs/CSOs to incorporate regular beneficiary feedback as part of the scheme.
    - Year 2 (2018) will see the start of PBF activities.

34. A detailed description of the PBF scheme design considerations is presented in Annex 4.

35. **Component 2 – Strengthening System-wide Enabling Factors that Support Delivery of Quality Health Services (US$35.0 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 measures that are more short term in nature, such as the strengthening of data collection and use for improved evidence-based decision-making, the implementation of normative instruments and regulations for the health sector, as well as those that have more of systemic characteristic, such as 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. In this sense, the component will assist the sector in improving its overall coordination and strengthen the stewardship role of the MOH for a more effective and better quality frontline service delivery.

36. **Accordingly, Component 2 will provide support the MOH to:** (i) improve the overall functioning of the pharmaceutical sector, including pharmacosurveillance and regulation, and particularly the procurement and distribution (supply chain) of medicines; (ii) build capacity in the production and management of a health workforce to increase the availability of providers at the local levels; (iii) strengthen national capacity, including the reinforcement of laboratory services, to detect and respond to public health outbreaks; (iv) develop a more reliable data and health intelligence, from the implementation of national surveys such as DHS and SDI and the advancement of the ministry's monitoring and evaluation capacity, to the strengthening of the national School of Public Health; and (v) improve the overall financing structure of the sector, including the development of a new financing model, the shifting of the flow of funds away

from an inputs-based approach, and strengthening the governance structures in the MOH in the area of procurement (including strategic procurement as part of Public Financial Management).

37. **Component 3 – Contingent Emergency Response Component (CERC) (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.

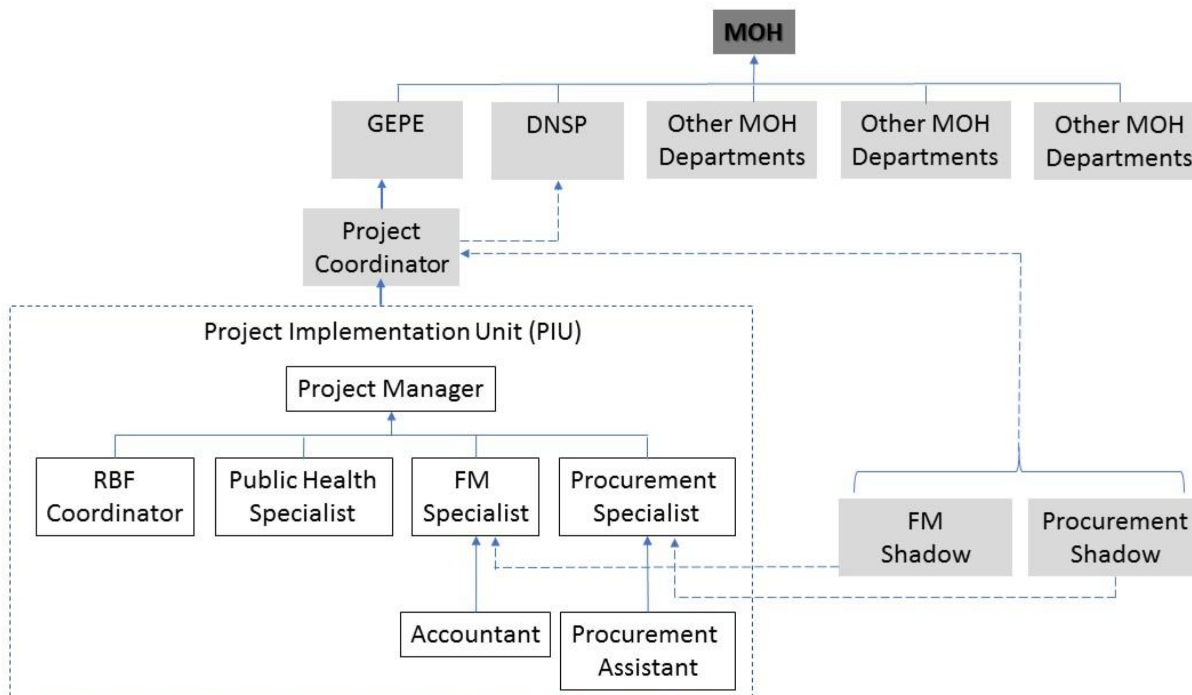
38. **Component 4 – Project Management and Monitoring and Evaluation (US$10M).** This component supports project implementation by the MOH, including project management, fiduciary tasks and Monitoring and Evaluation (M&E).

E. Implementation

39. The MOH will have overall responsibility for project implementation. The Project Implementation Unit (PIU) will be physically located within the MOH under the Department of Studies, Planning, and Statistics *(Gabinete de Estudos, Planeamento e Estatística (GEPE)*. The National Director of GEPE will be responsible for providing project oversight and ensuring project efforts are coordinated across the MOH and with other partner-supported initiatives. A Project Coordinator from within the ranks of MOH staff will lead the day-to-day implementation of the project and will report to: (i) the Director of GEPE on project interventions in MOH priority and strategic areas and on the coordination of efforts with other partners and will prepare and submit reports on a regular basis; and to (ii) the Director of the DNSP for the technical coordination of activities financed under the project. The Project Coordinator will be supported by a Project Implementation Unit (PIU) referred to as the Central Coordinating Unit (UCC in its Portuguese acronym). The PIU will consist of staff who will occupy the following roles: a Project Manager, a PBF Project Coordinator, a Public Health Specialist, an M&E Specialist, a project Financial Management (FM) Specialist, and a Procurement Specialist, who all report to the Project Manager, who in turn reports to the MOH-appointed Project Coordinator. In addition, the PIU will include support functions for the financial management and procurement areas. To further support the fiduciary capacity and to begin to build fiduciary capacity within the MOH, the MOH will identify two MOH staff who will shadow the PIU’s Financial Management Specialist and Procurement Specialist. This institutional arrangement deviates from that established under the current Municipal Health Services Strengthening Project as it aims to build the PIU capacity within the MOH in a two-fold manner, first, by being housed within the MOH and not externally, and second, by incorporating MOH staff to take on key PIU roles and functions in an effort to build the capacity within the MOH. To support the MOH in establishing and building the PIU capacity within the MOH, the project will finance international consultants in the areas of Financial Management and Procurement for a defined period within the project duration who will begin to train the MOH staff who can then directly participate and eventually take on fiduciary positions which have in the past been

handled by the PIU. The internationally recruited PIU Financial Management and Procurement Specialists will train the MOH staff identified to shadow them so they can begin to take on key financial management and procurement functions within a period between 12 to 24 months. Furthermore, the PIU team will be supported by technical staff of the MOH for each specific technical area of the project, such as health financing, public health, human resources for health, health information systems, epidemiology, among others. In addition, a PBF coordinator will manage the PBF aspect of the project. Figure 2 below provides a visual overview of the MOH structure that will support and implement the project.

Figure 2. Institutional Arrangements



40. At the provincial level, Provincial Health Directors are responsible for the implementation of the project. Their role is to coordinate program implementation in the municipalities that are part of the province. To strengthen implementation capacity in each of the seven provinces, the project will contract a technical support team of two persons: (i) a public health systems specialist; and (ii) an M&E Specialist. The Provincial Health Directorate will appoint finance staff to handle the project funds that will be channeled to the municipal level to facilitate payment of activities at the provincial and municipal levels. Those finance staff will be trained in the management of decentralized project funds. The MOH will enter into subsidiary agreements with the target provinces which will outline the respective share of responsibilities.

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

The project will target women of reproductive age and children under five in 21 municipalities in a total of seven provinces, of the country's total of 162 municipalities in 18 provinces. This project would also add an additional province and four municipalities selected based on the population to be reached, accessibility, availability of infrastructure, and population density as a proxy for poverty. In applying these criteria, the target intervention areas represent 4.7 million people (16.6 percent of the country's total population) and include: (1) Bengo: Ambriz e Dande, (2) Luanda: Icolo Bengo, (3) Lunda Norte: Chitato, Cambulo, Cuango, Lucapa, (4) Malanje: Cacuso, Calandula, Malanje, Caculama (Mucari), (5) Moxico: Comanongue, Luau, Luena (Moxico), (6) Uige: Maquela do Zombo, Negage, Sanza Pombo, Uige, and (7) Cuando Cubango: Cuito Cuanavale, Mavinga, Menongue. The project aims at improving the performance of 288 primary health care facilities (117 health posts, 93 health centers and 22 municipal hospitals) in the target municipalities. The primary health care facilities were selected by considering: (i) all municipal hospitals, (ii) health centers and MCH centers, (iii) general hospitals were excluded, (iv) some stations and health centers excluded (in Moxico and Malange) as the catchment population opts to access other health facilities. In addition, health facilities in Cuando Cubango are based on estimates from the HAMSET project experience. The MOH has an initial list of the health care facilities that would be targeted through this project. This list is based on the health care facilities reached and supported under the current Municipal Health Services Strengthening (MHSS) Project and the "mapa sanitarios" (health sector assessments) that were conducted for the provinces and include data on operating health facilities across municipalities in each province. These health care facilities will be confirmed during implementation by updating the "mapas sanitarios" which involves a field-based review of the operating health care facilities. For Cuando Cubango, the new province to be targeted through the project, a first "mapa sanitario" will be conducted since one has not been developed for this province before. There is an RPF and IPPF to guide the screening of possible impacts once the facilities have been confirmed.

G. Environmental and Social Safeguards Specialists on the Team

Kristyna Bishop, Social Safeguards Specialist
Paulo Jorge Temba Sithoe, Environmental Safeguards Specialist
Mario Rizzolio, Social Safeguards Specialist
Nadia Henriqueta Gabriel Tembe Bilale, Environmental Safeguards Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Proposed activities under the Angola Health System

	Performance Strengthening Project (HSPSP) (P160948) project include construction and upgrading of a National School of Health (Training Center) in Luanda under Component 2, which could lead to some adverse environmental and social impacts such as siting, solid and liquid waste generation, treatment and disposal, noise, vibration, dust emission, increased traffic, including risks to the health and safety of the construction workers and surrounding communities. Given the nature of the foreseen works, it is anticipated that most activities will fall under Categories B, since potential environmental and social impacts are site-specific, minimal, and can be easily mitigated using appropriate tools. With a view to determine appropriate impact mitigation measures for those activities, and ensuring the environmental and social sustainability of the proposed activities, OP/BP 4.01 Environmental Assessment was triggered and the borrower prepared an Environmental and Social Management Framework (ESMF) to determine the extent of environmental and social considerations required preceding the carrying out of activities of this Project, including detailed budget and training and capacity building needs. The ESMF underwent a process of public consultation and was disclosed on December 8, 2017. Under component 1, the project will finance activities aimed at improving the quality of the health care services in the target provinces and municipalities, which could to serious environmental health risks to healthcare workers and community associated with healthcare waste handling, treatment and disposal. A Health Care Waste Management Plan (HCWMP) was prepared and indicated that healthcare waste and contaminated healthcare waste handling, storage and disposal, have become a topic of national concern, especially as it presents a threat to public health and environmental. 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. Hence, The HCWMP was adopted by the borrower as a useful tool to provide guidance and procedures

		to mitigate impacts associated with environmental health risks. The HCWMP includes detailed budget provisions for mitigation measures and capacity building, monitoring and reporting requirements at all levels of project implementation.
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	Yes	A rapid social assessment was undertaken and it confirmed that there are San indigenous peoples in two of the provinces in which the project will be implemented: Moxico and Cuando Cubango. As the exact locations of the investments will not be identified until implementation, an Indigenous Peoples Planning Framework (IPPF) was prepared to provide guidance including 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	OP 4.12 has not been triggered as project financed activities are focused on strategic planning and improving access to services already offered by the health care system and will not require any land acquisition or displacement. The only physical investment is the construction of the National School of Public Health and it will be constructed on state owned land that can be shown to be clear of any physical occupation or economic activity. Screening criteria is included in the ESMF.
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.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:

The proposed HSPSP project is a Category B project as all identified potential impacts for the project components are considered site-specific; reversible or amenable to management actions, and in all cases mitigation measures can be readily designed. Potential environmental and social impacts in HSPSP include, but are not limited to the following: soil erosion (resulting from vegetation clearance and excavations of soils for activities such as the rehabilitation and construction of new sites); dust and air pollution; the likely disruption of the integrity of plant and animal populations and sensitive ecosystems; risks of infections and spread of diseases, increases in HIV/AIDS rates as a result of the influx of temporary workers coming in to the worksite; risks of water-borne illnesses resultant from still waters/ sewerage treatment; incidents and accidents in the workplace, as well as noise and vibrations and social conflicts, amongst others. Because project designs for the construction of the national School of Public Health are yet unknown, the potential impacts presented in the Environmental and Social Management Framework (ESMF) are general and serve as a guideline for a thorough assessment once the specific details have been concluded. The impact assessment should consider the scope of potential interventions. Although some negative impacts are expected from this project, there are also significant positive impacts that may counteract the negative ones. The positive impacts include: improved health status of populations in Angola, safe and healthy environments, improved livelihoods and economic stimulation as a result of a much healthier population, amongst others.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:

Construction of the National School of Public Health to be financed under this project will be undertaken in already designated site, exactly adjacent to the already existent public health in Luanda neighborhood. As such, anticipated environmental and social risks are minor and temporary. Morover, no land acquisition or impacts on forest or areas of important habitats or cultural heritage are expected as a result of the proposed project activities. OP 4.12 is not triggered for this project as project financed activities are focused on strategic planning and improving access to services already offered by the existing health care system and will not require any land acquisition or cause any negative impacts on livelihoods.

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

The project will finance construction and upgrading of laboratories under Component 2, which could lead to some adverse impacts such as siting, solid and liquid waste treatment infrastructure, and construction waste. Consequently, OP/BP 4.01 Environmental Assessment was triggered and an ESMF was prepared which sets forth guidance and procedures to adequately manage such impacts. Envisaged construction or renovation activities to be financed under the project will be undertaken on already designated sites, in most cases in premises were public health facilities are already located. As such, no land acquisition or impacts on forest or areas of important habitats are expected in this project.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.

Angola has a legislative and regulatory framework, which is conducive to good environmental management. The Project Implementing Unit (PIU) has experience and is familiar with fiduciary guidelines and safeguards policies and have implemented previous World Bank financed projects, namely, the Municipal Health Service Strengthening

(P111840). The PIU has designated a dedicated Safeguards Focal Point to ensure the project safeguards requirements are complied with. Notwithstanding, both the ESMF and Health Care Waste Management Plan (HCWMP) include detailed budget provisions and capacity building requirements to ensure effective intra-institutional coordination to comply with appropriate implementation of the proposed mitigation measures for continued improvements in environmental and social management.

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

Public consultation contributed to the elaboration of the safeguards documents as they provided important guidance and elements which should be addressed in detail during the preparation and implementation of the project's activities. The results of consultations were duly captured and included in Safeguards instruments prepared for the project and such results have been used in making the final decisions of the final Reports.

All relevant information necessary for the consultation was provided in a timely manner to the public, prior to the consultation, in a form and language understandable and accessible to the groups consulted. In terms of disclosure of information, all reports related to the consultation process, including ESMF and HCWMP reports were made available in a public place (Government of Angola portal and Ministry of Health website) accessible to the affected and interested groups including non-governmental organizations. These reports will be formally disclosed in-country and also in the World Bank sites prior to appraisal.

OP 4.10 has been triggered as San indigenous peoples live in two of the provinces in which the project will be implemented (Moxico and Cuando Cubango). As the exact locations of the investments will not be identified until implementation, an IPPF was prepared to provide guidance including 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.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
03-Nov-2017	08-Dec-2017	

"In country" Disclosure

Angola
10-Nov-2017

Comments

Disclosure was carried out through publication of the ESMF and HCWMP on the Government of Angola portal, the Ministry of Health website and the Bank portal.

Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank	Date of submission for disclosure
05-Dec-2017	21-Dec-2017

"In country" Disclosure

Angola
21-Dec-2017

Comments

The IPPF was shared for internal Bank review and clearance on December 5. Upon finalization of review and receipt of clearance, it will be disclosed through the Government of Angola portal, the Angola Ministry of Health website, and the World Bank portal.

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

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?
No

OP/BP 4.10 - Indigenous Peoples

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?
Yes
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?
Yes
If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?
NA

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?
Yes
Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?
Yes

All Safeguard Policies

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

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

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

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

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