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

Appraisal Stage | Date Prepared/Updated: 21-Nov-2018 | Report No: PIDISDSA25662

Public Disclosure Authorized

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Angola	P168956	Child Health Expansion Angola	P160948
Parent Project Name	**Region**	**Estimated Appraisal Date**	**Estimated Board Date**
Angola Health System Performance Strengthening Project (HSPSP)	AFRICA	05-Nov-2018	30-Jan-2019
Practice Area (Lead)	**Financing Instrument**	**Borrower(s)**	**Implementing Agency**
Health, Nutrition & Population	Investment Project Financing	Republic of Angola	Ministry of Health

Proposed Development Objective(s) Parent

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

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	9.70
Total Financing	9.70
of which IBRD/IDA	0.00
Financing Gap	0.00

DETAILS

Non-World Bank Group Financing

Trust Funds	9.70

Integrating Donor-Financed Health Programs	9.70

Environmental Assessment Category

B-Partial Assessment

Decision

The review did authorize the team to appraise and negotiate

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.** 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 fiscal balances and threatening to undo recent economic and social development progress. The country's per capita growth rate was 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 and external imbalances and a rising debt burden, which was

[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.

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. **The 27-year presidency of José Eduardo dos Santos ended in 2017, with a new government under the leadership of João Lourenço committing to address the country's imminent development challenges.** In September 2017, Angola held parliamentary elections marking the first peaceful political transition since independence. João Lourenço was elected president and has made a commitment to deliver on long-promised economic reforms, creating optimism about Angola's future. The new government faces formidable challenges to sustainably reduce poverty and boost shared prosperity. Angola's oil dependency creates macro-economic imbalances and the challenges across the governance system add to these binding constraints. These binding constraints must be lifted to allow an opportunity for reducing poverty and boosting shared prosperity in a sustainable manner.

Sectoral and Institutional Context

5. **While key health outcome indicators are improving, Angola continues to lag comparator countries.** Life expectancy at birth has increased by fourteen years since the beginning of this century, infant mortality has dropped by 56 percent and maternal mortality has decreased by half, placing Angola closer to the Sub-Saharan (SSA) average. Despite this progress, Angola still generally falls behind poorer comparators, such as the group of low-income countries (LIC) and well below its closer comparators, the lower-middle-income countries (LMIC) (see Table 1). The Multiple Indicator Cluster Survey (MICS) for 2015-2016 further shows that 38 percent of under-five 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.

Table 1: Life expectancy and mortality rates in Angola, Sub-Saharan Africa (SSA), low-income countries (LIC), and lower-middle-income countries (LMIC), 2000-2017

	2000	2005	2010	Latest Available Year
Life Expectancy at birth				
Angola	47.1	52.8	58.2	61.5 (2016)
SSA	50.5	53.1	56.9	60.4
LIC	53.6	56.7	60.1	62.9
LMIC	62.7	64.3	66.2	67.9
Infant Mortality Rate (per 1,000 live births)				
Angola	122.6	101.8	76.4	53.8 (2017)
SSA	93.0	78.3	65.1	51.5
LIC	88.1	73.0	61.1	48.6
LMIC	66.7	56.6	47.4	36.8
Maternal Mortality Rate (per 100,000 live births)				
Angola	924.0	705.0	561.0	477.0 (2015)
SSA	846.0	717.0	625.0	547.0
LIC	796.0	674.0	570.0	479.0
LMIC	421.0	343.0	291.0	257.0

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

6. **Furthermore, Angola's Human Capital Index (HCI) falls below the Sub-Saharan Africa average and that of income comparators.** The HCI measures the human capital that a child born today can expect to attain by age 18, given the risks to poor health and poor education that prevail in the country where he/she lives. The HCI exhibits substantial variation across countries, ranging from 0.3 in the poorest countries to 0.9 in the best performers. In the case of Angola, which has a HCI equal to around 0.36, this means the country is near the poorest performers and if current education and health conditions in Angola persist, a child born today will only be 36 percent as productive as he/she could have been relative to the benchmark of complete education and full health. As shown in Table 2 below, in two of the three HCI health indicators of child survival to age five and in the fraction of children under five not stunted, Angola performs below the Sub-Saharan Africa (SSA), LIC, and LMIC averages. Furthermore, Angola falls below the LMIC average for survival rate from age 15-60, which is defined as the fraction of 15-year-olds that survive until age 60[4].

[4] Methodology for a World Bank Human Capital Index, September 2018. This paper was prepared by Aart Kraay (World Bank Development Research Group, akraay@worldbank.org) as a background paper for the World Development Report 2019 and for the World Bank's Human Capital Project.

Table 2: Human Capital Index and Components. Regional and Income Group Benchmarks

Indicator	Angola Male + Female	Sub-Saharan Africa Male + Female	Low Income Male + Female	Lower Middle Income Male + Female
HCI Component 1: Survival				
Probability of Survival to Age 5	**0.918**	0.930	0.925	0.960
HCI Component 2: School				
Expected Years of School	**7.9**	8.1	7.8	10.2
Harmonized Test Scores	**326**	374	363	392
HCI Component 3: Health				
Survival Rate from Age 15-60	**0.764**	0.733	0.744	0.810
Fraction of Children Under 5 Not Stunted	**0.624**	0.685	0.658	0.735
Human Capital Index (HCI)	**0.36**	0.40	0.38	0.48

Source: Human Capital Index database, September 14, 2018

7. **These poor health outcomes reflect failures in service delivery, symptomatic of a dysfunctional health system in need of 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 Ministry of Health (MOH) constrains more informed technical decisions at the local level. There is also a lack of accountability on how funds are used by the provinces and municipal directorates, as they are transferred by the Ministry of Finance (MOF) without any links to national goals or performance. Budget execution rates at the municipal level are high, but there are many signs of inefficient resource use: health posts and municipal hospitals are not always functional, health workers' classifications are frequently outdated, and staff are frequently absent.

8. **Several quality-related issues undermine healthcare outcomes.** Quality is hampered by a scarce 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. The quality of pharmaceutical products is also a concern, as storage conditions are often inadequate, especially for products requiring temperature control. Angola has also no national quality-control laboratory and counterfeit medicines are in circulation. As the 10 mini-laboratories that were introduced in 2012 to screen the quality of medicines at entry points are insufficient to cover all imported pharmaceuticals, some products must be sent to laboratories in Portugal and Brazil for screening. A 2005 USAID report estimated that 70 percent of drugs were purchased in informal markets, 35 percent of them were counterfeit drugs.[5]

9. **Health spending (both total and public) compares unfavorably with countries at the same or lower income levels.** Over the past sixteen years (2000-2015), per capita health expenditure in Angola, fell short of

[5] 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.

both its regional peers and its comparators' average, the LMIC group. Angola's total health expenditure, when measured as a percentage of GDP also falls short of the poorer LIC group (see Table 3). Public spending accounted for about 54 percent of total health expenditure between 2000 and 2015. While this level is significantly higher than comparators, the government allocates a very small share of the budget (generally less than 5 percent) to the health sector. This explains the overall low levels of health spending in Angola compared to other mineral-rich countries outside SSA, such as Bolivia, Ecuador, Colombia, Mexico and Malaysia.

Table 3: Healthcare expenditure in Angola, SSA, LIC, and LMIC, 2000-2015

	2000	2005	2010	2015
Total Health Expenditure per capita (constant international $ of 2011				
Angola	87.9	157.1	161.6	183.6
SSA	128.3	167.3	170.6	186.6
LIC	59.3	78.3	93.6	92.0
LMIC	119.5	157.8	187.4	243.3
Total Health Expenditure (% of GDP)				
Angola	2.5	4.0	2.7	2.9
SSA	5.4	5.5	5.3	5.4
LIC	4.3	5.3	6.2	6.0
LMIC	3.8	4.0	3.8	4.0
Public Health Expenditure (% of government expenditure)				
Angola	2.3	5.1	4.3	3.7
SSA			9.9	
LIC				
LMIC		5.4	5.3	
Out-of-pocket Health Expenditure (% of total expenditure on health)				
Angola	25.0	39.8	19.3	33.4
SSA	32.7	34.5	33.8	36.3
LIC	48.9	45.9	46.0	44.2
LMIC	60.1	61.5	57.5	57.3

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

10. **Recent progress in health outcomes is threatened by crisis-related cut-backs to health spending.** Per capita public spending in the health sector increased by more than four times in real terms during the oil boom years of 2000 and 2013, but the share of public spending on health declined with lower growth post 2014. This pattern was reinforced by public spending cuts in 2014, 2015 and 2017 which lowered government spending on health by 16, 11 and 2 percent, in real terms, respectively. As a result, in real terms, government spending in 2017 was similar to the levels observed in 2013. Spending on immunization programs fell by 50 percent from 2014 to 2015, and data from the 2015/16 MICS suggest that vaccination rates for DTP and Polio-3 have dropped to about 40 percent in 2015.

11. **After the civil war, Angola embarked on a process of decentralization, which involved the administrative decentralization of the public health system (*Sistema Nacional de Saúde*, SNS).** The SNS encompasses the 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; and the promulgation of regulations. Provincial governments have the responsibility to manage the provinces' network of health services and have to ensure that all units operate within their allocated provincial budgets. Municipal governments are increasingly managing the primary health care network and 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. **Lack of accountability and coordination mechanisms between central and local authorities in the formulation of the health budget make it difficult 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 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. As part of the budget process, provincial governments submit budget proposals from the provincial directorates of health and education (*Delegação Provincial de Ensino e de Saúde*) to the MoF. The MoH also submits its own budget proposal to the MoF which covers support operations and policy departments, and the financing of services for which the ministry is directly responsible; these include the construction and maintenance of regional and national hospitals. There is 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; as a result, hospitals and municipal administrations are becoming *de facto* budgetary units, responsible for executing their own budgets. While provincial and municipal level have complete autonomy over health services under their responsibility, the lack of coordination misses the opportunity to agree on shared priorities that should be addressed across the entire national health system.

C. Proposed Development Objective(s)

Original PDO

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

Current PDO

Key Results

13. In order to measure the impact of the child health expansion financed through the proposed AF, two key results will be monitored to measure the impact of the AF activities in supporting the delivery of child health services. These are:

- number of child health consultations through Mobile Health Brigades in the urban/peri-urban municipalities
- number of children immunized in the urban/peri-urban municipalities

D. Project Description

14. **Angola needs to improve financing mechanisms that can play a role in incentivizing improved performance for more effective and efficient health service delivery.** Angola has been pursuing decentralization efforts since the early 2000s, and while decentralization has empowered municipalities, it has also created new challenges for effective management of government financing and delivery of health services. Angola needs more effective and efficient service delivery, and well-designed financing mechanisms can play a role in incentivizing improved performance. Currently, funds are transferred from provinces to the municipal directorates or municipal hospitals according to historic costs or local budget projections, which do not take into account the real cost of services and/or quality indicators. The influence of municipal budgeting exercises on final allocations is unclear, as the results of municipal-level planning are not clearly linked to final allocations from the Ministry of Finance (MOF). MOF allocations to the provincial-level have been based on historical line item budgeting and availability of resources, the latter which has been challenged with the economic downturn. To help address key factors contributing to this challenge, the Government of Angola with the World Bank prepared the HSPSP to strengthen the delivery of quality primary health care services at the provincial and municipal level, while in parallel, working to strengthen the national health system which includes empowering the national level Ministry of Health in its strategic stewardship role of advocating for the health sector across different levels of the system.

15. **Through a partnership with the Global Alliance Vaccine Initiative (GAVI), an Additional Financing (AF) of US$9.7 million to the HSPSP will focus on strengthening the delivery of child health services.** GAVI is co-investing through the HSPSP project not only because this is perceived to be the most efficient way of significantly impact immunization coverage, but because GAVI believes that co-investing through the HSPSP will strengthen government systems for financing and for an integrated and comprehensive approach to service delivery. Out of an initial list of 18 municipalities with the highest share of under-immunized children, 13 municipalities in four provinces have been selected to receive GAVI additional financing to support the delivery of child health services, with a focus on integrating immunization services to primary health care service delivery. The 13 municipalities are: Benguela, Cubal, Lobito in the province of Benguela; Cabinda in the province of Cabinda; Cela and Sumbe in the province of Cuanza Sul; and Belas, Cacuaco, Cazenga, Kilamba Kiaxi, Maianga, Sambizanga, and Viana in the province of Luanda. These 13 targeted urban/peri-urban municipalities in the four provinces concentrate 50.8 percent of the country's non-immunized children and represent a total population of 9,324,468, of which 396,290 are children under five. Of the 396,290 children under five in these 13 municipalities, 125,511 are not immunized – that is 32 percent of under five children in these 13 municipalities are not immunized (125,111/396,290). However, when compared to the total number of under/non-immunized children under-five at the national level (246,736), the 13 target municipalities concentrate 50.8% of the non-immunized children across Angola (125,111/246,736) (Table 4).

Table 4: Non-immunized Children in GAVI Additional Financing Target Municipalities

Province	Municipality	Population	Children under 5	Non-immunized children	Immunization Coverage (%)
BENGUELA	Benguela	592,520	25,182	5,947	76
BENGUELA	Cubal	322,359	13,700	3,297	75
BENGUELA	Lobito	414,592	17,620	3,229	82
CABINDA	Cabinda	658,832	28,000	7,301	74
CUANZA SUL	Cela	237,862	10,109	4,907	51
CUANZA SUL	Sumbe	295,290	12,550	4,094	67
LUANDA	Belas	1,133,949	48,193	20,405	58
LUANDA	Cacuaco	1,128,715	47,970	20,749	57
LUANDA	Cazenga	941,241	40,003	13,497	66
LUANDA	Kilamba Kiaxi	887,461	37,717	10,776	71
LUANDA	Maianga	631,374	26,834	3,729	86
LUANDA	Sambizanga	387,126	16,453	8,638	47
LUANDA	Viana	1,693,147	71,959	18,942	74
	TOTAL	**9,324,468**	**396,290**	**125,511**	
			Total non-imunized children (Angola)	**246,736**	
			% non-immunized children in 13 municipalities	*50.8%*	

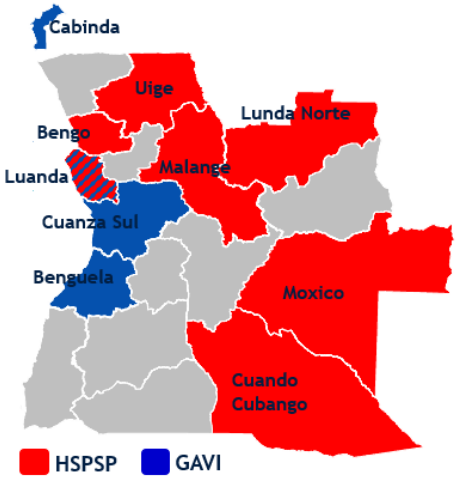
Source: Ministry of Health 2018
Note: Coverage refers to all immunizations under the Expanded Program of Immunizations (EPI)

16. **The GAVI AF focus on child health services in urban/peri-urban municipalities directly complements the HSPSP focus on maternal and child health services in rural municipalities.** HSPSP targets women of reproductive age and children under the age of five in 21 rural municipalities in a total of seven provinces, of the country's total of 162 municipalities in 18 provinces. The HSPSP target municipalities were selected to maintain the service delivery coverage under the Municipal Health Services Strengthening Project (MHSS) (P111840) which was under implementation from September 2009 to June 2018. Under the MHSS project, the target provinces and municipalities were selected based on the seven criteria used under the government's Revitalização Program[6] which aimed to improve the quality of health services, their utilization, and equity in access to and availability of health services. The selection criteria applied under the MHSS included: (i) population to be reached, (ii) health status, (iii) accessibility, (iv) availability of infrastructure, (v) inclusion in the decentralization program, (vi) availability of staff, drugs, and supplies, and (vii) the presence of UNICEF and WHO. The HSPSP used the MHSS selection criteria as a base and further assessed the population to be reached, accessibility, availability of infrastructure, and population to be reached based on the 2015/2016 MICS data. In applying these criteria, the following provinces and municipalities were selected as the target intervention areas which represent 4.7 million people (16.6 percent of the country's total population): *Bengo*: Ambriz e Dande; *Luanda*: Icolo e Bengo; *Lunda Norte*: Chitato, Cambulo, Cuango, Lucapa; *Malanje*: Cacuso, Calandula, Malanje, Caculama (Mucari); *Moxico*: Camanongue, Luau, Luena (Moxico); *Uige*: Maquela do Zombo, Negage, Sanza Pombo, Uige; and *Cuando*

[6] Revitalização dos Serviços Municipais

Cubango: Cuito Cuanavale, Mavinga, Menongue.

Figure 1. Target Provinces under the HSPSP and GAVI financing



Source: Angola World Bank Health Task Team, October 2018

17. **Despite Angola having transitioned from GAVI support, the country was identified as being "at risk" to roll-back immunization progress thereby making it eligible for post-transition support.** Although Angola is now classified by GAVI as "fully self-financed", the country's recent progress in health outcomes is threatened by crisis-related cut-backs to health spending. Public spending cuts in 2014, 2015, and 2017 lowered government spending on health. As a direct result, spending on immunization programs fell by 50 percent from 2014 to 2015. According to the GAVI eligibility policy, Angola fully transitioned out of GAVI support as per January 1, 2018. Nevertheless, Angola, along with Congo and Timor-Leste, has been identified as being "at risk of successful transition" due to current low immunization coverage and other governance, financing and programmatic challenges. A proposal for post-transition support to Angola was presented and validated in principle during the last GAVI Board meeting of June 2018. The proposal includes three main areas of interventions: (a) advocacy strategy towards the new administration on health and immunization financing, vaccine procurement, emergencies and epidemics and coordination and consultation of partners; (b) innovative human resources capacity building; and (c) urban strategy to increase immunization coverage in targeted areas (with highest number of unimmunized children).

18. **The GAVI "at risk" classification of Angola is a reflection of the country's deteriorated macroeconomic environment, however, the Government is committed to sustain the level of health service delivery and gains.** Despite the absence of counterpart funding for the AF, the Government has engaged further on the prioritization of health and immunization by organizing an "Immunization Forum" to be chaired by the President in November 2018 (following the Addis Declaration) and committed to increase the health budget from 4% in 2018 to 12.5% by 2019 and 15% by 2021. Moreover, this renewed political engagement is evidenced by the government's continued self-financing of the Expanded Program of Immunizations (EPI)[7] vaccines and its supporting activities

[7] The Expanded Programme on Immunization (EPI) was established in 1974 to develop and expand immunization programs throughout the world. In 1977, the goal was set to make immunization against diphtheria, pertussis, tetanus, poliomyelitis,

through its Expanded Vaccination Program known as the Programa Alargado de Vacinação (PAV) in Portuguese. To support the overall national program, GAVI will make parallel, smaller investments through other implementing partners where those partners are considered to have comparative advantage. These include UNICEF which will focus on further supporting service delivery in the provinces of Huila and Cunene where they have had an active engagement in the last years, and WHO that will focus on local-level planning and coordination.

19. **To make an impact towards the more challenged child health outcomes, the enhanced partnership with GAVI will focus on strengthening the delivery of an integrated package of child health services.** As reflected in the HCI data, Angola's child survival rates to age 5 and stunting are below regional and income-level comparators. The partnership with GAVI will provide a focused approach to addressing child health services in an integrated manner across the health system. This integrated approach involves reinforcing the primary health care (PHC) level as the entry and first point-of-care in the health system by ensuring the availability of not only equipment but also trained professionals and service protocols. This will be further supported by the availability of adequate vaccination rooms that include cold chain equipment at the PHC facility-level as an effort to move away from a system that has historically focused on immunization campaigns. An integrated child health service delivery approach will ensure that disease-specific health programs do not operate in a vertical or siloed manner to ensure a package of services can be effectively provided to the target community in a coordinated manner. This integrated package includes key interventions such as complementary nutrition, fortification (vitamin A, iron and folic acid tablets), immunization, health check-ups, treatment of minor ailments, and referral services. Furthermore, opportunities for coordination with other sectors will be explored, such as education to reinforce the importance of preschool education and with water and sanitation for the convergence of other supportive services. By reinforcing the PHC-level as the entry point of care, missed opportunities of care for mothers and children will be diminished as a visit to a PHC-facility will be an opportunity to follow-up on the delivery of the integrated package of child health services and not treated as a stand-alone visit.

20. **While the AF will have a focus on the integrated delivery of child health services, it will also build on GAVI's experience and expertise to ensure immunizations under the integrated package are sustained.** The most recent estimates of population immunization coverage in Angola by WHO/UNICEF are around 50 percent DTP3. Given this, the AF will work directly with PAV to ensure immunization coverage rates are not only maintained, but improved not only for DTP3, but on more routine vaccination coverage with all EPI antigens, a more rigorous approach than solely targeting DTP3. Furthermore, the routine vaccinations will be intensified under the AF in the 13 beneficiary municipalities by tapping into the media using Portuguese and local languages. The integrated approach to the delivery of child health services will help improve the efficiency of fixed vaccination posts by creating vaccination rooms in health units with high care where they do not yet exist and taking full advantage of vaccination opportunities for children and women of childbearing age who present themselves in health facilities for any other reason.

21. The Expansion of Child Health Care AF will rely on globally recognized good practice strategies to ensure an integrated approach to the delivery of child health services. These include:

- Integration of immunization services: Recent studies in Africa have shown an adverse effect of immunization

measles and tuberculosis available to every child in the world by 1990. The major challenges now facing the EPI are accelerating and sustaining national immunization efforts.

campaigns on overall immunization coverage.[8,9,10] The AF proposes as a central strategy the integration and horizontalization of the EPI, which remains verticalized to a certain extent. In Angola, there has been a great need for integrating maternal and child health services for years. Integrated health care for the mother and child contributes to the well-being of both mothers and children, addressing many health needs and offering them the convenience of receiving multiple services in a single visit. Training and supervision, logistics and registration systems are particularly essential for integration. The probability of success is greater when management and management actions are integrated into the provision of services, so that policies, planning, budgeting, training of professionals, and financing support the integrated service delivery.

- Rapid Monitoring of Vaccination Coverage/ Active Search of susceptible population: Rapid Monitoring of Vaccine Coverage (RCM) is an extremely useful method for defining or redefining vaccination actions, improving vaccine coverage and homogeneity of coverage. It is characterized by being a field activity, going from house-to-house, at which time, the vaccination card of the resident that is part of the target group of the vaccination is evaluated for one or more vaccines. It is a direct method of evaluation providing information on the proportion of vaccinated individuals in relation to the total of individuals evaluated at the home visit. It will be employed when it becomes necessary to evaluate the vaccination status of children and women of certain target groups, vaccinating house to home, improving vaccination coverage and homogeneity of coverage in the context of municipalities.
- Mobile Brigades to populations with difficult access to fixed services: It is an intervention usually conducted by a mobile team integrating several professionals organized, equipped and trained to offer a package of health services to populations with difficult access to healthcare at a distance above 20 km from the health unit responsible for population.
- Expansion of the Fixed Vaccination Network: Additional Vaccination Units will be created, including supply of equipment and material for the Municipalities and training for the health personnel (see below). It is estimated that 10 fixed vaccination units will be created for the seven municipalities in Luanda province, with an additional four units for the three other provinces (two in Benguela, one in Kuanza Sul, and one in Cabinda). These units do not imply construction, but include adaptations of spaces, small repairs, installation and maintenance of equipment.
- Training of Human Resources: Health professionals will be trained for the new rooms and continuous training will be provided for those who already work in the fixed units. Training will be carried out with the support of the EPI and will cover the following contents: Living Conditions and Population Health Problems; Knowledge of the Epidemiological Chain of Diseases; Rupture of the Epidemiological Chain of Diseases; Conservation of vaccines; Preparation and Administration of vaccines; Evaluation of the Vaccination Result; The day-to-day in the vaccination room; How to attract children and women for vaccination; Understanding the Planning Process; and What can we do to vaccinate all children. There will be two training sessions in Luanda and one in each of the other provinces to train the new professionals for the new rooms. In the remaining units there will be one continuous training session per month per unit. There will be 12 continuous formations per year for each unit in each of the 13 Municipalities. In addition to staff training for the new rooms and continuous training, the necessary training will be developed to introduce the following tools into the 13 municipalities: Management Tool for Planning and Budgeting (FPOM in its Portuguese acronym) and the District Health Information System 2 (DHIS2).

[8] Mounier-Jack, S., Edengue, J. M., Lagarde, M., Baonga, S. F., & Ongolo-Zogo, P. (2016). One year of campaigns in Cameroon: effects on routine health services. *Health Policy and Planning*, *31*(9), 1225–1231. http://doi.org/10.1093/heapol/czw054

[9] Closser S, Cox K, Parris TM, et al. 2014. The impact of polio eradication on routine immunization and primary health care: a mixed-methods study. Journal of Infectious Disease 210 Suppl 1: S504–13. [PMC free article] [PubMed]

[10] Griffiths UK, Mounier-Jack S, Oliveira-Cruz V, et al. 2011. How can measles eradication strengthen health care systems? Journal of Infectious Disease 204 Suppl 1: S78–81. [PubMed]

- Urban and Peri-urban Social Mobilization, particularly in the Municipalities of Luanda: The seven Municipalities of Luanda concentrate 96,736 unvaccinated children. In order to reach this large urban and peri-urban population, more effective use of mass media will be necessary, including the use of mass media campaigns, involvement of public personalities and musicians, messaging in large marketplace areas, and targeting messages for dissemination in public transportation using the "Candongueiro", a local name used in Angola for the traditionally painted blue and white mini-bus/van that provides passenger transportation.
- Routine vaccination checks during campaigns: Although this subproject will not specifically support immunization campaigns, the sub-project staff will have procedures to check and fill in gaps in routine immunization.

22. **In order to measure the impact of the child health expansion financed through the proposed AF, two indicators will be added to the Project Results Framework.** The indicators being introduced include one at the PDO-level and the other at the intermediate indicator level. At the PDO-level, the current indicator on the "number of child health consultations" and at the intermediate-level, the current indicator on "the number of children immunized" will be complemented by AF-specific indicators. These AF-specific indicators will add the geographic scope of the AF intervention to capture progress in reaching the target population in the urban/peri-urban municipalities. These indicators are detailed in Section II below.

E. Implementation

Institutional and Implementation Arrangements

23. **This AF will be implemented through the existing HSPSP PIU, in close collaboration with the Extended Program on Immunization (EPI).** The HSPSP PIU accumulates implementation experience from the two previous World Bank-funded projects: The HIV/AIDS, Malaria and Tuberculosis Control (HAMSET) Project and the Municipal Health Services Strengthening (MHSS) Project. The PIU retained the procurement team from the previous project (with performance rated as Moderately Satisfactory), which will ensure the GAVI AF can be operationalized in a timely manner, especially as it pertains to the procurement of equipment for vaccination rooms, medicines and supplies needed for the delivery of child health services.

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

The Child Health Expansion Angola project will target children in 13 new municipalities that are not covered under the HSPSP. The 13 new municipalities are: Benguela, Cubal, Lobito in the province of Benguela; Cabinda in the province of Cabinda; Cela and Sumbe in the province of Cuanza Sul; and Belas, Cacuaco, Cazenga, Kilamba Kiaxi, Maianga, Sambizanga, and Viana in the province of Luanda. These municipalities represent a total population of 9,324,468, of which 396,290 are children under 5.

G. Environmental and Social Safeguards Specialists on the Team

Benjamin Burckhart, Social Specialist
Nadia Henriqueta Gabriel Tembe Bilale, Environmental Specialist
Santiago Estanislao Olmos, Social Specialist

SAFEGUARD POLICIES THAT MIGHT APPLY

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	Like the Parent Project, the HSPSP AF was classified as Category B owing to the nature and scale of the anticipated environmental and social impacts which will be minor and localized. As such, the AF will trigger OP/BP 4.01 to ensure that appropriate environmental and social considerations related to the incremental use of medicinal supplies that may lead to increased healthcare waste generation are captured and dealt with accordingly. The AF will finance the delivery of the child health services package to an additional 13 peri/urban municipalities. The distribution of medical supplies such as immunizations may contribute to an increase in healthcare waste generation, thus resulting in potential risks to the public and health workers as a result of handling and disposal healthcare waste. Consequently, the existing ESMF and HCWMP were updated to reflect the scope of the HSPSP AF. This updating process included the review of the capacity of the borrower to manage additional safeguards requirements brought by the AF activities.
Performance Standards for Private Sector Activities OP/BP 4.03	No	The project will not work in the area of performance standards for private sector activities.
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	No	Since no ancestral territories or particular groups meeting the four criteria (meeting the definition of Indigenous Peoples OP 4.10) have been identified to date in the four provinces (Luanda, Kwanza Sul, Cabinda and Benguela) targeted by the AF, OP 4.10 is not triggered.
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 Additional Financing (AF) will finance the delivery of the child health services package (immunizations) to an additional 13 urban/peri-urban municipalities. Anticipated enviromental and social impacts will be localized, temporary and easily manageable with the use of the existing safeguards instruments. Although proposed activities may lead to an increase in medical waste generation, the AF does not trigger additional safeguard policies. The parent project triggered OP/BP 4.01, as some activities will finance the acquisition of medical supplies and equipment and involve some civil works. Moreover, with the guidance of the Bank, the PIU have successfully prepared an action plan and delivered a series of trainings related to Biosafety and Healthcare Waste Management to address some of the pertaining challenges to implement healthcare waste management. Consequently, the existing safeguard instruments, the Environment and Social Management Framework (ESMF) and the Health Care Waste Management Plan (HCWMP) prepared under the parent project which were publicly disclosed in-country and at the infoshop on December 8, 2017, provide adequate guidance and concrete actions to address and mitigate impacts associated with the project antcipated risks. Notwithstanding, to ensure that any incremental environmental and social risks that may arise from the proposed activities under the AF are duly addressed, the ESMF and HCWMP were updated accordingly to reflect the necessary changes brought by the activities of the AF. These updated safeguards documents were publically disclosed on the Government of Angola website on November 21, 2018.

Given the nature of the proposed activities (no construction or rehabilitation of facilities are expected) the AF will not require involuntary taking of land that could result in permanent or temporary physical displacement, loss of assets or livelihoods or loss of cultural heritage. OP 4.12 on involuntary ressettlement and OP 4.11 on physical Cultural Ressources are not triggered for this project. Similarly, since no ancestral territories or particular groups meeting the four criteria (meeting the definition of Indigenous Peoples OP 4.10) have been identified to date in the four provinces (Luanda, Kwanza Sul, Cabinda and Benguela) targeted by the AF, OP 4.10 is not triggered.

Despite the fact that 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 children 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:
Proposed project activities are not expected to have any long-term and irreversible adverse environmental and social impacts. Like the parent project, impacts from the AF investments will be in general, localized, temporary, of low magnitude and easily dealt with through the application of existing safeguards instruments. As such, the project is not expected to generate or contribute to any cumulative impacts. On the contrary, project investments may strengthen sound environmental and social practices around the health sector through the application of the existing HCWMP were duly updated and redisclosed.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
The delivery of the child health services package will be limited to the health facilicies of 13 urban/peri-urban municipalities which were carefully selected based on preliminary analysis carred out by the Global Alliance Vaccine Initiative (GAVI) and the World Bank in determining the expansion of coverage. The preliminary analysis indicates that these locations have the potential to greatly maximize the AF outcomes. Unlike others municipalities countrywide, the selected locations have basic procedures in place to ensure adequate management of he anticipated, albeit localized environmental and social adverse risks. All the municpaliies have specific healhcare waste management protocols and manuals which were prepared in the course of implementation of the Municipal Health Services Strenthening (MHSS) project which closed on June 30, 2018 and the preparation of the parent 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 PIU has experience and is familiar with fiduciary guidelines and safeguards policies and have implemented previous World Bank financed projects, namely, the MHSS project. Throughout the implementation of MHSS project, the PIU was supported by a dedicated Safeguards Focal Point to ensure that project safeguards requirements were complied with. Moreover, borrower´s awareness of healthcare waste management procedures has increased over the years. As evidence of this growing awareness, during the original project preparation a HCWMP was prepared, 30 staff received training in biosafety and healthcare waste management in the provinces covered by the project, and a series of operational healthcare waste management protocols were elaborated. For this AF, the existing HCWMP was updated and redisclosed to include the expansion of the geographical scope and client targeted strategic capacity building in safeguards. As further support, the Bank will provide close supervision to ensure the basic recommendations of the existing safeguards instruments and tools are incorporated.

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 provide important guidance and elements which should be addressed in detail during the preparation and implementation of the project activities. The results of consultations were duly captured and included in the safeguards instruments prepared for the project and such results have been used in making the final decisions in the 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 the disclosure of information, all reports related to the consultation process, including the 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 were formally disclosed in-country and also in the World Bank sites.

A Stakeholder Engagement Plan (SEP) is included as part of the ESMF. The SEP identifies a technically and culturally appropriate approach to consultation and disclosure. The goal of the SEP is to improve and facilitate decision-making and creating an atmosphere of understanding that actively involves project-affected people and relevant stakeholders in a timely manner, to ensure these groups are provided sufficient opportunity to voice their opinions and concerns that may influence Project decisions. The SEP identifies in detail the key stakeholders as well as the mechanisms of consultation for project implementation.

B. Disclosure Requirements (N.B. The sections below appear only if corresponding safeguard policy is triggered)

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
12-Nov-2018	19-Nov-2018	

"In country" Disclosure

Angola
21-Nov-2018

Comments

The ESMF and the HCWMP were both publically disclosed on the Government of Angola website on November 21, 2018.

If the project triggers the Pest Management and/or Physical Cultural Resources policies, the respective issues are to be addressed and disclosed as part of the Environmental Assessment/Audit/or EMP.

If in-country disclosure of any of the above documents is not expected, please explain why:

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting) (N.B. The sections below appear only if corresponding safeguard policy is triggered)

OP/BP/GP 4.01 - Environment Assessment

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

CONTACT POINT

World Bank

Carmen Carpio
Senior Operations Officer

Borrower/Client/Recipient

Republic of Angola
Ciel da Conceicao de Aguiar Cristovao

General Director
ciel.cristovao@minfin.gov.ao

Implementing Agencies

Ministry of Health
Antonio Zacarias Costa
Director Gabinete de Estudos, Planeamento e Estatística (GEP
ngaveia.felix@gmail.com

FOR MORE INFORMATION CONTACT

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

APPROVAL

Task Team Leader(s):	Carmen Carpio

Approved By

Safeguards Advisor:	Maman-Sani Issa	21-Nov-2018
Practice Manager/Manager:	Gaston Sorgho	21-Nov-2018
Country Director:	Elisabeth Huybens	22-Nov-2018