OFFICIAL USE ONLY
R2018-0039/2

March 21, 2018

Closing Date: Thursday, March 22, 2018 at 6:00 p.m.

FROM: Vice President and Corporate Secretary

Angola – Angola Health System Performance Strengthening Project

Extension of Closing Date

Due to the inclement weather and the closure of WBG Washington, D.C. offices in effect Wednesday, March 21, 2018, the closing date for the proposed loan to Angola for an Angola Health System Performance Strengthening Project (R2018-0039) is being extended to **Thursday, March 22, 2018**.

Distribution:
Executive Directors and Alternates
President
Bank Group Senior Management
Vice Presidents, Bank, IFC and MIGA
Directors and Department Heads, Bank, IFC and MIGA

OFFICIAL USE ONLY
R2018-0039/1

March 2, 2018

Closing Date: Wednesday, March 21, 2018 at 6:00 p.m.

FROM: Vice President and Corporate Secretary

Angola – Angola Health System Performance Strengthening Project

Project Appraisal Document

Attached is the Project Appraisal Document regarding a proposed loan to Angola for an Angola Health System Performance Strengthening Project (R2018-0039), which is being processed on an absence-of-objection basis.

Distribution:
Executive Directors and Alternates
President
Bank Group Senior Management
Vice Presidents, Bank, IFC and MIGA
Directors and Department Heads, Bank, IFC and MIGA

Document of

The World Bank

FOR OFFICIAL USE ONLY

Report No: PAD2563

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$110 MILLION

TO THE

REPUBLIC OF ANGOLA

FOR A

ANGOLA HEALTH SYSTEM PERFORMANCE STRENGTHENING PROJECT (HSPSP)

February 28, 2018

Health, Nutrition & Population Global Practice
Africa Region

CURRENCY EQUIVALENTS

Exchange Rate Effective: January 31, 2018

Currency Unit	=	Angolan Kwanza (Kz)
Kz 165.096	=	US$1
US$.00600	=	Kz 1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Makhtar Diop
Country Director:	Elisabeth Huybens
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Gaston Sorgho
Task Team Leader(s):	Carmen Carpio

ABBREVIATIONS AND ACRONYMS

ADECOS	Agentes de Desenvolvimento Comunitário e Sanitário (Community Development and Health Agents)
CHW	Community Health Workers
CPS	Country Partnership Strategy
DHIS2	District Health Information Software 2
DHS	Demographic Health Survey
ESMF	Environmental and Social Management Framework
EU	European Union
FM	Financial Management
GDP	Gross Domestic Product
GR	Grievance Redress
HAMSET	The HIV/AIDS, Malaria and TB Control Project
HCWMP	Health Care Waste Management Project
HIS	Health Information System
HNP	Health, Nutrition, and Population
HRH	Human Resources for Health
LMIC	Lower Middle-Income Country
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MICS	Multiple Indicators Cluster Survey
MHSS	Municipal Health Services Strengthening
MOF	Ministry of Finance
MOH	Ministry of Health
PASSII	Projecto de Apoio ao Sector da Saúde II (Health Sector Support Project II)
PBF	Performance Based Financing
PDO	Project Development Objective
PHC	Primary Health Care
PIU	Project Implementation Unit
PND	Plan Nacional de Desenvolvimento (National Development Plan)
PNDS	Plano Nacional de Desenvolvimento em Saúde (National Health Development Plan)
PPSD	Project Procurement Strategy for Development
RBF	Results Based Financing
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDI	Service Delivery Indicators
SNS	Serviço Nacional de Saúde (National Public Health System)
SSA	Sub Saharan Africa
UHC	Universal Health Coverage
UMIC	Upper Middle-Income Country
USAID	United States Agency for International Development
WHO	World Health Organization

BASIC INFORMATION

Is this a regionally tagged project?	Country(ies)	Financing Instrument
No		Investment Project Financing

[ ] Situations of Urgent Need of Assistance or Capacity Constraints

[ ] Financial Intermediaries

[ ] Series of Projects

Approval Date	Closing Date	Environmental Assessment Category
21-Mar-2018	30-Sep-2023	B - Partial Assessment
Bank/IFC Collaboration		
No		

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

Component Name	Cost (US$, millions)
Improving the Quality of Health Services Delivery in Target Provinces	65.00
Strengthening System-wide Enabling Factors that Support Delivery of Quality Health Services	35.00
Contingent Emergency Response Component (CERC)	0.00
Project Management and Monitoring and Evaluation	10.00

Organizations

Borrower :	Republic of Angola
Implementing Agency :	Ministry of Health

PROJECT FINANCING DATA (US$, Millions)

[ ] Counterpart Funding	[✓] IBRD	[ ] IDA Credit	[ ] IDA Grant	[ ] Trust Funds	[ ] Parallel Financing

Total Project Cost:	Total Financing:	Financing Gap:
110.00	110.00	0.00
	Of Which Bank Financing (IBRD/IDA): 110.00	

Financing (in US$, millions)

Financing Source	Amount
IBRD-88350	110.00
Total	**110.00**

Expected Disbursements (in US$, millions)

Fiscal Year	2018	2019	2020	2021	2022	2023
Annual	0.79	8.31	13.88	27.79	42.94	16.28
Cumulative	0.79	9.10	22.98	50.77	93.72	110.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

Yes

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	High
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Substantial
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10	✓	
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Sections and Description

Section I. Implementation Arrangements. B.2. The Borrower shall carry out the Project in accordance with a financial management manual, to be adopted not later than one hundred and twenty (120) days after the Effective Date, satisfactory to the Bank ("Financial Management Manual"), which shall contain detailed guidelines, methods and procedures for the implementation of the Project, including: (i) administration and coordination; (ii) budget and budgetary control; (iii) disbursement procedures and banking arrangements; (iv) financial, procurement and accounting procedures; (v) receipt of goods and payment of invoices; (vi) internal control procedures; (vii) accounting system and transaction records; (viii) reporting requirements; (ix) audit arrangements; (x) corruption and fraud mitigation measures; guidance for funds flow and payments related to the results based financing scheme; and (xi) and such other arrangements and procedures as shall be required for the effective implementation of the Project; and except as the Bank shall otherwise agree in writing, not amend or waive, or permit to be amended or waived any provision of the Financial Management Manual.

Sections and Description

Section I. Implementation Arrangements. A.2. 2. The Borrower shall appoint not later than ninety (90) days after the Effective Date, and thereafter maintain within the PIU, at all times during the implementation of the Project, the following specialists, all under terms of reference, and with qualifications and experience satisfactory to the Bank: (i) a Project manager; (ii) a public health specialist; (iii) a monitoring and evaluation specialist; (iv) a financial management specialist; (v) a procurement specialist; and (vi) any other such specialists as may be agreed,

as further detailed in the PIM. The Project implementation unit shall be further supported by technical staff of the MoH assigned to each specific technical area of the Project, such as health financing, public health, human resources for health, health information systems, epidemiology, among others, as further detailed in the PIM.

Sections and Description
Section IV. Other Undertakings. The Borrower shall, not later than one hundred and twenty (120) days from the Effective Date, train staff responsible for finance within Target Provinces and Municipalities who will handle funds at the provincial and municipal level under terms and conditions acceptable to the Bank.

Sections and Description
Section IV. Other Undertakings. The Borrower shall, not later than one hundred and twenty (120) days from the Effective Date, purchase and install a computerized accounting service for the Project acceptable to the Bank.

Sections and Description
Section IV. Other Undertakings. The Borrower shall, not later than ninety (90) days from the Effective Date appoint a financial management specialist and one hundred and twenty (120) days from the Effective Date appoint two (2) accountants to support the Project implementing unit.

Sections and Description
Section IV. Other Undertakings. The Borrower shall, not later than one hundred and twenty (120) days from the Effective Date, appoint a project and an independent external auditor under terms and conditions acceptable to the Bank.

Conditions

Type	Description
Disbursement	Notwithstanding the provisions of Part A of the Project Legal Agreement, no withdrawal shall be made for payments against activities under Part 1(b)(ii) of the Project under Category (2), unless and until the Borrower has prepared and adopted the PBF Manual, in form and substance satisfactory to the Bank, and in accordance with Section I.B.3 of Schedule 2 to the Financing Agreement.
Effectiveness	The Additional Condition of Effectiveness consists of the following, namely the adoption by the Borrower of a Project Implementation Manual in form and substance satisfactory to the Bank.
Disbursement	Section III. Withdrawal of Loan Proceeds, B.1.c. under Category (6), for Emergency Expenditures under Part 3 of the Project, unless and until the Bank is satisfied, and notified the Borrower of its satisfaction, that all of the following conditions have been met in respect of said activities:

	(i) the Borrower has determined that an Eligible Crisis or Emergency has occurred, has furnished to the Bank a request to include said activities in the Emergency Response Part in order to respond to said Eligible Crisis or Emergency, and the Bank has agreed with such determination, accepted said request and notified the Borrower thereof; (ii) the Borrower has prepared and disclosed all Safeguards Instruments required for said activities, and the Borrower has implemented any actions which are required to be taken under said instruments, all in accordance with the provisions of Section I.G of Schedule 2 to this Agreement; (iii) the Borrower's Coordinating Authority has adequate staff and resources, in accordance with the provisions of Section I.E of this Schedule 2 to this Agreement, for the purposes of said activities; and (iv) the Borrower has adopted an Emergency Response Manual in form, substance and manner acceptable to the Bank and the provisions of the Emergency Response Manual remain, or have been updated in accordance with the provisions of Section I.E of this Schedule 2 so as to be, appropriate for the inclusion and implementation of said activities under the Emergency Response Part.

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Carmen Carpio	Team Leader(ADM Responsible)	Health Systems	GHN13
Laurent Mehdi Brito	Procurement Specialist(ADM Responsible)	Procurement	GGOPF
Amos Martinho Malate	Procurement Specialist	Procurement	GGOPF
Joao Tinga	Financial Management Specialist	Financial Management	GGOAC
Ana Maria Carvalho	Team Member	Ag Resident Representative	AFMAO
Angela Maria Lopes Delfino	Counsel	Senior Counsel	LEGEN
Benjamim Mutti	Team Member	Country Office Support	AFCC1
Jesus Alberto Lino	Team Member	Country Office Support	AFMAO
Jose C. Janeiro	Team Member	Loan	WFACS
Kristyna Bishop	Social Safeguards Specialist	Social Development	GSU01
Lais Miachon Silva	Team Member	Public Health	GHN13

Mario Rizzolio	Social Safeguards Specialist	Social Development	GSU01
Marize De Fatima Santos	Team Member	Health Systems	GHN04
Nadia Henriqueta Gabriel Tembe Bilale	Environmental Safeguards Specialist	Environmental	GEN07
Paulo Jorge Temba Sithoe	Environmental Safeguards Specialist	Environmental	GEN01
Roberto F. Iunes	Team Member	Health Economics	GHN04
Sofia De Abreu Ferreira	Counsel	Senior Counsel	LEGEN

Extended Team

Name	Title	Organization	Location
Alfredo Perazzo	Results based financing Consultant		La Plata,Argentina

ANGOLA
ANGOLA HEALTH SYSTEM PERFORMANCE STRENGTHENING PROJECT (HSPSP)

TABLE OF CONTENTS

I. STRATEGIC CONTEXT

A. 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 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.

B. Sector Context

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 the use of and access to basic services and worsen the country's already poor social outcomes, as discussed below. In this difficult macro-fiscal context, achieving

[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.

further progress on social indicators will require policymakers to identify and protect—or even increase—expenditures in critical social sector areas, while developing new strategies to mobilize additional resources and enhancing both the allocative and technical efficiency of health and education spending.

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 consistent 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, five 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. The maternal mortality ratio 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. Finally, 2015-16 data from the Multiple Indicator Cluster Survey (MICS) 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 utilization 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 (eight 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 of direct obstetric deaths. Other risk factors include teenage pregnancy and the short intervals between births. Twenty-five 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

[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

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 and utilize health care services. In Angola, 33 percent of women ages 15-49 reported having been a victim of physical or sexual violence, with most 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. **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 rate is lower by 7 deaths per 1,000 births.[11]. There is also considerable inequality in the use of and 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. 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 utilizing health care services. 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.

Health sector financing and spending

9. **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, to that of 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 levels 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 in 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.

10. **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 has somewhat benefited by the economic boom and two-digit annual growth experienced by the country between 2004 and 2009, increasing to some extent its share of GDP and of the government budget. Per capita public spending in the health sector increased more than four times in real terms between 2000 and 2013. However, as economic growth decreases, the share of public spending on

[9] MICS 2015-2016
[10] MICS 2015-2016
[11] The MICS data do not allow for this level of disaggregation.

health decreases to lower proportions of 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 Diphtheria, Tetanus, and Pertussis (DTP) and Polio-3 have already dropped to about 40 percent in 2015.

Key institutional characteristics and constraints

11. **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.

12. **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 two km radius, compared to 63 percent of the urban population. About 79 percent of current public health facilities are functional, based on the results of a national health network mapping exercise conducted between 2007 and 2011.

13. **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, the General State Budget, which comprises the budget for central government agencies, such as the MOH, as well as the budget for all provincial 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 to the Ministry of Finance (MoF). The MOH also submits its own budget proposal to the MoF which includes its operating costs and policy departments, and financing of 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 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. The provincial governments allocate relevant budgets to hospitals, health centers, and municipal administrations resulting in the hospitals and municipal administrations becoming de facto budgetary units, responsible for executing their own budgets. In the end, the provincial and municipal level have complete autonomy over health services under their responsibility. 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

14. **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. 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.

15. **Several quality-related issues undermine the Angolan 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 referrals across the levels of the health system. Quality is further hampered by the very 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, community healthcare workers could supplement the health sector's limited human resources in the short run (Box 1). 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).[12] 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 must 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.[13] Finally, storage conditions are often inadequate, especially for products requiring temperature control.

[12] MICS 2015-16 and Inquérito Integrado Sobre o Bem-Estar da População (IBEP) 2008/09.
[13] 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 261,357 families. The CHWs were selected directly from their communities. CHWs worked in close coordination with midwives to educate pregnant women on prenatal care and vaccinations. The CHWs working in the districts most affected by a major cholera outbreak in 2007 were instrumental in containing the disease, especially through water treatment.

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 support the health system though public outreach. The health-specific role played by the ADECOS includes 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 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.

16. **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 this is sustainable. Moreover, there is a limited pool of students with the necessary academic background to receive further training. According to a 2014 MOH 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. The human-resource management system has insufficient information on the needs and movement of workers within provinces. Although national regulations specified in the Regulação do Sistema de Atendimento Primário (REGUSAP in its Portuguese acronym) 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.[14] As a result,

[14] 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.

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.

17. **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.

18. **Angola's health system is further strained by its vulnerability to 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. **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, PND* 2012-2017) 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 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 with the overarching objective being to strengthen the capacity and performance of the SNS to improve the health of the population, raise life expectancy, and promote a more active popular participation in the national economic and social development process.

C. Higher Level Objectives to which the Project Contributes

20. **Enhancing the quality of health service delivery to improve the quality of life of the population is one of the two pillars in the Country Partnership Strategy (CPS) FY14-16**. The CPS supports institutional reforms

and investments to create conditions favorable to improving health indicators, especially regarding child and maternal mortality. Strengthening of the health sector, by improving the quality of care across Angolan's health system, is critical to ensuring the delivery of quality health services at the provincial and municipal level which are the objectives of the proposed project. This is in line with the twin goals and the adoption of strategies aimed to boost shared prosperity. The proposed project is also in line with the Health, Nutrition, and Population (HNP) goal of ensuring Universal Health Coverage (UHC), specifically by focusing on one of the three HNP priority directions of service coverage. The draft Performance and Learning Review (PLR) envisions an extension of the CPS until FY19 and a reformulation of the objectives to respond to the macroeconomic challenges emerging from the oil price drop. The draft Performance and Learning Review includes the need for increasing the efficiency of social programs as one of the key objectives.

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

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

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

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

B. Project Beneficiaries

23. The project will target women of reproductive age and children under the age of five in 21 municipalities in a total of seven provinces, of the country's total of 162 municipalities in 18 provinces. Under the MHSS project, the target provinces and municipalities were selected based on the seven criteria used under the government's Revitalização Program[15] which aimed to improve the quality of health services, their utilization, and thus equity. These criteria 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.[16] 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 following provinces and municipalities will be 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 Cubango*: Cuito Cuanavale, Mavinga, Menongue.

24. The project aims at improving the performance of 232 primary health care facilities (117 health posts, 93 health centers and 22 municipal hospitals) in the target municipalities. This represents approximately 80 percent of the 288 health units estimated to exist in the 21 municipalities that will be supported through the project. The primary health care facilities were selected by considering: (i) all municipal hospitals, (ii) health centers and maternal and child health centers, (iii) general hospitals were excluded as they are not considered primary units, especially when municipal hospital exists, (iv) some stations and health centers were excluded (in provinces such as Moxico and Malange as they are not used due to a minimal catchment population that opts to utilize other health facilities). In addition, the health facilities to be targeted in the province of Cuando Cubango will be identified using a health facility survey ("mapa sanitario") that will be conducted under this project.

Table 1. Health Facilities in Target Provinces

Province	Units Considered	80% of Units Considered	Posts	Centers	Municipal Hospitals	Total
Luanda	24	16	11	4	1	16
Bengo	39	27	19	6	2	27
Lunda N.	45	31	19	7	5	31
Moxico	50	35	19	14	2	35
Malange	50	35	9	22	4	35
Uige	80	56	22	30	4	56
C. Cubango	*40	32	18	10	4	**32**
Total	**288**	**232**	**117**	**93**	**22**	**232**
***** Estimated number						

Source: Data provided by the Municipal Health Services Strengthening Project team

[15] Revitalização dos Serviços Municipais
[16] The seventh criteria indicating the presence of UNICEF and WHO will not be required to not limit the potential collaboration across agencies.

C. PDO-Level Results Indicators

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 who are HIV positive that deliver at a health facility
- Number of child health consultations conducted through Mobile Health Brigades
- Number of reproductive health consultations conducted through Mobile Health Brigades Number of consultations conducted through Mobile Health Brigades

Quality related indicators:
- Percentage of pregnant women who receive four ante-natal care (ANC) consultations
- Pregnant women who deliver at health facilities that are HIV positive and receive ART
- Percentage of pregnant women receiving two tetanus vaccines during pregnancy Number of health facilities without stock-outs of reproductive health medicines and supplies

III. PROJECT DESCRIPTION

A. Project Components

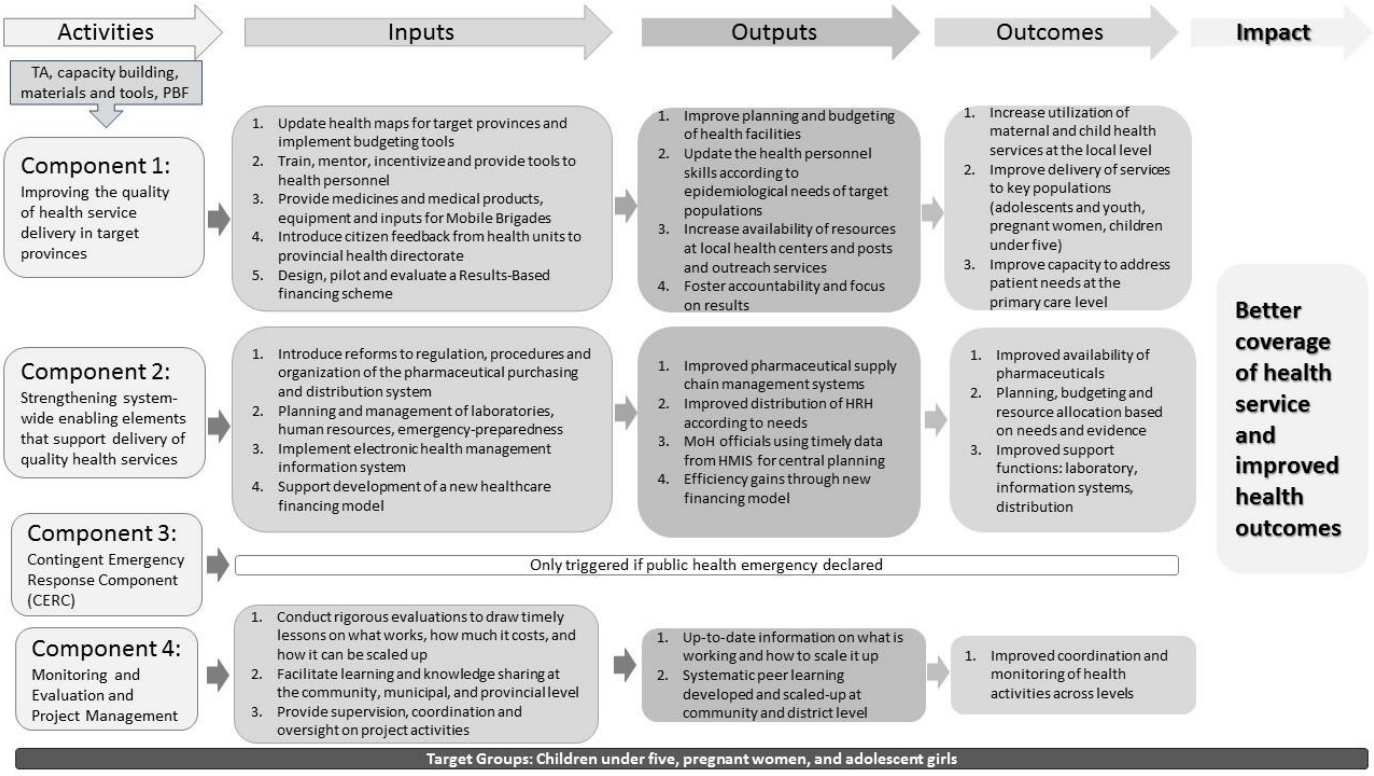
25. **The project components are structured to respond to Angola's key health sector challenges as laid out in the earlier sector context and diagnostic.** To achieve the goals defined by the PDO, the project will support efforts that directly address the utilization and quality of health services in 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.

26. **The project intervention areas are defined according to two basic criteria: ability to improve utilization 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[17] 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 the low utilization of health services and the inconsistent quality of these 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 supporting the utilization 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 supporting activities related to the strengthening of the national

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

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.

Figure 1. Project Theory of Change



27. **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.

28. **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. The improved quality of health services can lead to improved health service utilization which may indirectly lead to improvements in outcomes. An example of a pathway may be the renovation of primary care facilities leading to higher community acceptability, resulting in the increased use of health services as more children are brought for treatment and thus a reduction in deaths due to treatable causes.

29. 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 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. 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.

31. 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 April 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 together with the MOH team reviewed the basic package of health services supported by the Angola MOH. From this package, key interventions to be incentivized in line with the maternal and child health focus will be selected and costed using existing costing information and further Bank analysis. In parallel, the Bank team will work with the Social Protection sector and the Ministério da Administração do Território e Reforma do Estado (MATRE) to use existing social registries and the inputs for those being developed to support the identification and registration of the beneficiary population.

32. 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 validation process for the selection of results indicators against which disbursements will be made will involve the MOH working with the MoF to: (i) develop and manage the contracts that are to be entered into by the provinces/municipalities with the MOH 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.

33. As per discussion with the MOH, the PBF scheme will be piloted at the municipal level in two different provinces, to improve utilization of quality Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) services adjusted to the provincial and municipal level context through: a) providing PBF payments and small investment grants to eligible RMNCAH service providers (posts, centers and hospitals), in accordance with the qualitative and quantitative indicators specified in the PBF Manual. The provinces 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.

34. The PBF pilot will be implemented in a phased manner.
    - Year 1 (2018) 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. The preparation activities will include detailing out the validation process to be followed for the selection of the results indicators against which disbursements will be made. A set of indicators and targets will be established from the basic package of MCH services based on consultations to be held by the Provincial Health Directorates with the municipal health facilities and then validated with the MOH.
    - Year 2 (2019) will see the start of PBF activities.

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

36. **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. As such, this component is a critical underpinning for improving utilization because by improving quality, it will ensure better service delivery and coverage and hence will likely lead to utilization. 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.

37. 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 Demographic Health Survey (DHS) and Service Delivery Indicators (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).

38. **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 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.

39. **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).

B. Project Cost and Financing

Project Components	Project cost (US$ million equivalent)	IBRD or IDA Financing	Trust Funds	Counterpart Funding	% Financing
Component 1. Improving the Quality of Health Services Delivery in Target Provinces	**65.0**	65	0	0	100
- Subcomponent 1.1. Improving the Quality of Maternal and Child Health Services at the Provincial and Municipal Level	45.0	45	0	0	100
- Subcomponent 1.2. Piloting Performance-Based Financing	20.0	20	0	0	100
Component 2. Strengthening System-wide Enabling Factors that Support Delivery of Quality Health Services	**35.0**	35	0	0	100

Component 3. Contingent Emergency Response Component (CERC)	0	0	0	0	100
Component 4. Project Management and Monitoring and Evaluation	**10.0**	10	0	0	100
Total project cost	**110**	**110**	**0**	**0**	**100**
Front-end Fees	0.275	0.275	0		
Total financing required	**110.0**	**110.0**			

C. Lessons Learned and Reflected in the Project Design

40. **The project benefits from the previous implementation experiences of Bank-financed projects such as the HIV/AIDS, Malaria and TB Control Project (HAMSET, P083180).** HAMSET was a US$39.6 million project (approved in 2004 and closed in 2011), which aimed to reduce the spread of HIV/AIDS in the Angolan population, strengthen the capacity of the health sector to detect and treat TB, and strengthen the capacity of the MOH for effective case management of malaria. A key lesson learned from HAMSET is that despite the importance of addressing HIV/AIDS, TB, and malaria directly through a vertical-disease focused project, the poor maternal and child health indicators in Angola call for a broader intervention supporting the health system with specific maternal and child health interventions.

41. **In addition to HAMSET, the experience of the Municipal Health Services Strengthening Project (MHSS, P111840) also informs this new project.** MHSS is a US$70.8 million project (approved in 2010 and ongoing to 2018), which is financing the delivery of maternal and child health services in the provinces and municipalities which the current project will build on. The MHSS project highlights the importance of engaging the Government in the extensive analytical work and project preparation efforts required as part of a new project design which helps to ensure that institutional changes and the sustainability of investments are more likely with the strong government ownership. The MHSS project was developed in line with the Government's Revitalização program which aimed to strengthen primary health care service delivery at the municipal-level. This new project, similar to MHSS aligns to the Government program, in this case the health sector reform, which looks to strengthen the MOH stewardship role to help improve service delivery at the municipal level.

42. **Lessons from these earlier projects include the following:**

- **The need for local actors / provincial health directorates to be given more power to make decisions.** These decisions can include arrangements for the selection and hiring of project staff and identification of focal points for specific areas, in order to ensure greater ownership of the project at the local level. This empowerment at the local level would positively impact the implementation of activities together with the financial management which can contribute to the timely flow of funds at the local level and back to the central level.

- **Local decision-making needs to be accompanied by adequate mechanisms for the management of financial resources in the provinces**. These mechanisms need to consider the reality of the municipalities regarding banking; the disbursing based on results, and ensuring the project has

authority in the provinces to allow for effective control of resources at the local level.

- **The leadership and coordination role of the MOH is crucial to being able to make significant inroads to address Angola's most pressing health sector challenges.** This MOH leadership and coordination role needs to be strengthened both within the sector and with partners in a way that is effective for the project, in all thematic areas, from the central to the local level. This will allow for synergies to be established thereby allowing for the best use of limited resources to build on existing Government or donor partner efforts.

- **In the partnership for the training of the ADECOS, the MHSS should lead the process in its entirety.** The existing partnership for training of the ADECOS brings together the MOH with the with the Ministry of Territory Administration and State Reform (MTASR) and the Social Action Fund (FAS). Having the MOH in the clear lead can minimize frictions resulting from the differences between the vision and the working mechanisms, especially regarding procurement and financial management procedures. ADECOS cannot solely have the scope given by MTASR/FAS nor can they be given roles requiring treatment of patients nor prescribing medication. However, if the ADECOS are properly trained and adjusted to their potential and profile, they can provide valuable contributions in terms of social mobilization of the most vulnerable populations at the community level.

43. **This project also takes into account lessons learned from other Low and Middle Income countries in designing and implementing RBF.** Lessons on RBF are derived from the design and implementation of both Bank and non-Bank operations, especially the supply-side. Key lessons which are helping to inform the Angola PBF pilot include:

- Zimbabwe. The Angola PBF pilot is firmly anchored in lessons learned from implementing the RBF mechanism in 18 rural districts in Zimbabwe through the Health Sector Development Support Project. In Zimbabwe, the Bank and the Government built the overall technical design of the project in direct alignment with the country's health sector priorities as defined in the National Health Strategy. The Angola PBF follows Zimbabwe's path by piloting the PBF as a direct response to the Government's priority to introduce performance-based measures in the health sector.

- Cameroon. In Cameroon, the PBF scheme engaged different implementing agencies to operate in a set of pilot regions, each developing a program that responded to the context-specific challenges of their region. The Angola PBF experience, as in Cameroon, will initiate as a pilot in a set of regions (municipalities in Angola) to respond to the specific contextual challenges.

- Nigeria. The experience of the Nigeria States Health Program Investment Project demonstrates that strong state leadership results in preliminary improvements in quality and the quantity of targeted health outcomes, along with staff motivation and client satisfaction. In this line, as part of the Angola PBF, an active consultation process with key decision-makers will be part of the design process of the scheme and will include a national-level workshop to bring key actors together on launching PBF in Angola.

- Rwanda. The Rwanda Community Living Standards Grant emphasized that incentives matter. The Angola PBF will create incentives to expand the coverage of MCH interventions and improve their quality by linking facility payments to service delivery and quality indicators.

- Panama. The Health Equity and Performance Improvement (HEPI) Project underscored the importance of cross-sectoral partnerships (e.g. between health and social protection) which can promote innovation, and simultaneously address supply and demand-side barriers to improved utilization of health services. The Angola PBF experience will benefit from the social protection efforts underway to establish a beneficiary registry which can serve as the base for registering the potential beneficiary population under the PBF pilot in Angola. In addition, in coordination with social protection, an analysis of potential indicators to include in the scheme in nutrition are being assessed.

- Tajikistan. The Tajikistan Health Improvement Project highlighted the need to engage early and at all levels of the health system to ensure buy-in into the design and institutional setup of RBF. In Angola, it will be critical to ensure the municipal level has an active voice and sense of ownership from the design to implementation.

- Global. An overall experience from across PBF global experiences is the need for improved governance through better verification and oversight of performance. The communities and civil society can be involved in the verification of the health facility quality and in assessing results of health service delivery results and by publishing results on a public website. The Angola PBF will incorporate verification and counter-verification into its scheme.

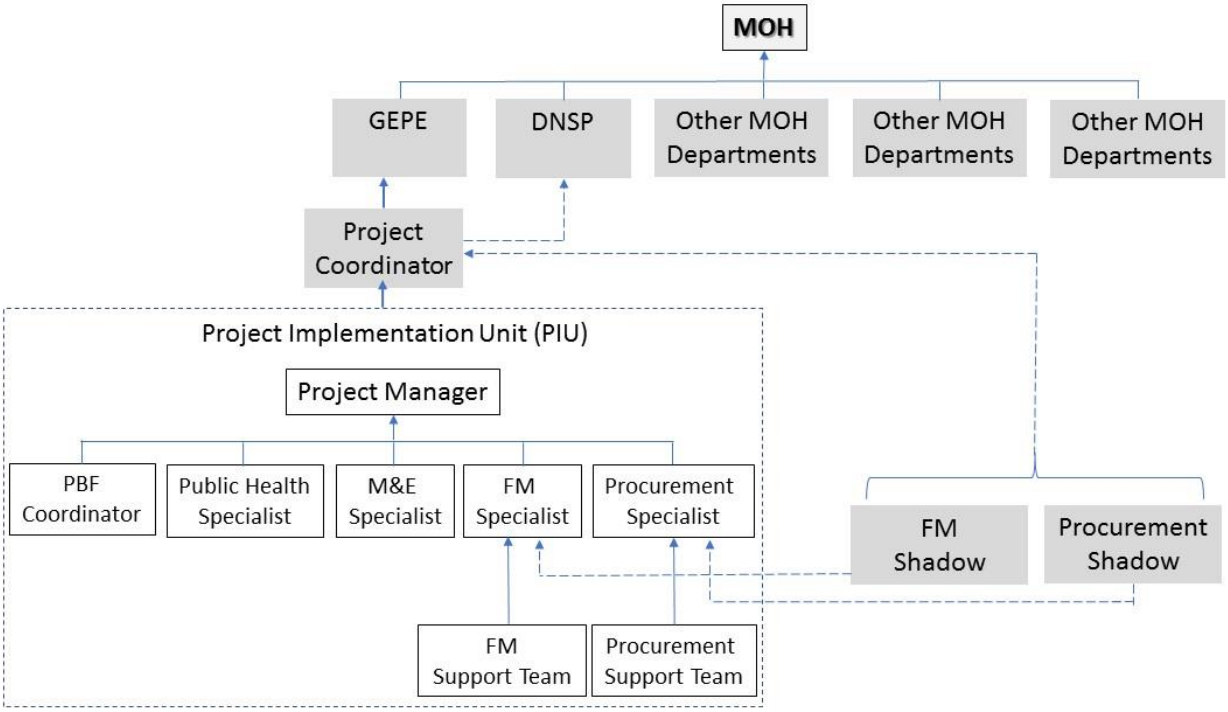
IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

44. 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



45. 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.

B. Results Monitoring and Evaluation

46. **A detailed Results Framework, is included in Section VII.** The progress and results of project implementation will be monitored on a routine basis throughout the life of the project.

47. **The general principle underlying the M&E approach is the alignment with M&E processes** developed for the previous World Bank-funded project and the existing monitoring and evaluation frameworks and systems of the Ministry of Health. As described above, the Component 2 of the proposed project includes activities aimed at strengthening health information systems and monitoring and evaluation capacity in the health system. The monitoring of project performance will directly benefit from those activities.

48. **Data to monitor the progress towards achieving the PDO and intermediary indicators will be collected through existing information systems and platforms and M&E tools developed through the PRSMS Project**. The current health information system (*Sistema de Informação de Saúde* – SIS) integrates information from vertical programs such as the Advanced Vaccination Program (PAV – *Programa Avançado de Vacinação*), HIV/AIDS, Malaria and Tuberculosis programs, and routine production data from healthcare facilities. In addition, tools developed through PRSMS facilitate compilation of key routine data from the municipal and *comuna* level. The M&E specialist of the PIU will compile and report the data on the indicators based on the SIS routine data collection and on activities carried out by the respective MINSA sectors (e.g. Human Resources Directorate regarding training of health personnel). A consultant will be hired to conduct a baseline study for all indicators in the results framework.

49. **The Project will continue to support the GoA's efforts towards the implementation of the District Health Information Software 2 (DHIS2)** as a tool for digitizing data collection for SIS in the first two years of Project implementation. As such, it is expected that data to monitor progress towards Project indicators will eventually be collected through DHIS2. The World Bank, alongside other partners of the Angola health sector, supported earlier efforts towards the implementation of DHIS2.

50. **Two additional types of data collection will be implemented to supplement routine data collection**: a) population-based health survey (Multiple Indicator Cluster Survey [MICS] and Demographic and Health Survey [DHS] and b) service quality assessments (service delivery indicators [SDI] survey). A baseline MICS/DHS survey was conducted in 2015 with support from the previous World Bank operation in Angola. The Project will co-finance an additional MICS/DHS survey to be conducted in 2020. The 2015 MICS/DHS provides data on the sector background and baseline data for some of the key project indicators. Results of the 2020 survey will provide insight onto results from the first two years of Project implementation. The MICS/DHS and SDI surveys will be conducted by the National Statistics Institute (*Instituto Nacional de Estatística* – INE), which has previously collaborated with the World Bank in the Angola Health and Education Public Expenditure Review (P151501).

51. **Ongoing process documentation and a process evaluation will be conducted as part of the mid-term review** (2021) to understand success and barriers to the implementation and achievement or results under the Project. The findings will inform discussions with key regional and national stakeholders and contribute to course corrections as needed. It will not be possible to conduct an impact evaluation of the project using traditional methodologies (e.g., random control trials). However, impact evaluations are planned for specific project elements, such as the Results-Based Financing pilot intervention. The evaluation results will determine whether the current or future World Bank financed Project will support the scale up of the PBF scheme to additional areas of the country.

C. Sustainability

52. **The project will work within the priority areas articulated in the current (2012-2017) and new (2018-2022) National Health Development Plan (PNDS).** The thrust of the PNDS 2012-2017 is to improve primary health care, the delivery of maternal and child health (MCH) services, and vaccination coverage in key MCH areas. The PNDS 2018-2022 emphasizes the need to strengthen the national capacity and management of the national health system, recognizing the instrumental role of the MOH in the governance of the decentralized health service delivery system. The PNDS 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 national health system 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.

53. **As part of the reform, the Government is committed to developing and implementing a new health financing model to improve the efficiency and results of the health system.** The health sector, as a share of the government budget is less than 5 percent compared to the 15 percent recommended by the Abuja Declaration. A part of the additional fiscal space could be explored through the PBF scheme to be piloted through this project. In this line, the Government has committed to dedicating project resources to test PBF on small, focused scale to assess the opportunities it can bring for increased efficiencies in health expenditures through the achievement of better results for the same amount of funding. The PBF scheme is described in greater detail in Annex 4.

54. **Moreover, many Development Partners are eager to join the Government and the World Bank efforts to finance and technically support the priority health sector reform areas.** The World Health Organization (WHO) and other key on-the-ground partners such as the European Union, the United States Agency for International Development (USAID), and the Global Alliance for Vaccines Initiative (GAVI) have been active participants in the Government's efforts to develop a new health financing model for the country. Initial assessments conducted by the World Bank (2017 PER) and the World Health Organization's health financing study provide initial data and background on the context. The Government is leading a health financing working group which looks to take this work to scale and use the new project to support the continued analytical work and implementation of key first steps.

55. **Sustainability is not only financial but also technical and institutional**. The project will provide technical strengthening support to the MOH and MOF through training activities, international and national technical assistance included in the project, and additional technical assistance financed outside the project as parallel and complementary activities. These include the Health Financing Assessment to understand the budgeting and management processes at the municipal level with GAVI, and continuing to support the analytical work and implementation plan for a new health financing model with WHO.

D. Role of Partners

56. **This project will benefit from the experiences of other donor-financed projects supporting the health sector in Angola.** The proposed project would benefit from the support provided by the Projecto de Apoio ao Sector da Saúde *(*PASS II) financed by the European Union (EU) for US$34 million across the 2013 to 2019 period. PASS II has supported the development of normative instruments to strengthen the regulatory

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

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

57. The overall project rating is substantial with the project facing one high risk, four substantial risks, and three moderate risks as described below.

58. High Risks. **The macroeconomic risk is considered high.** The risks related to the current macroeconomic environment are rated *high* given that the project builds on government systems which depend on public revenues to function. Any further deterioration of the macroeconomic environment (e.g., inflation, further devaluation of the Kwanza) may not only affect the Government's ability to provide services but also further decrease the ability of the Government to sustain the level of health service delivery (supply-side), particularly to those most in need and thus affect the impact of the project. To manage this risk, the Government has provided for an increase in the budgetary allocation for the education and health sector in the 2018 State General Budget. The Bank team has been working with the Government in producing a set of policy notes with recommended actions to support the increased allocation for education and health.

59. Substantial Risks. **The political/governance, institutional capacity for implementation and sustainability, fiduciary and stakeholder risks are all considered *substantial***. The political/governance risks are substantial. Elections were held on August 2017, ending a long-standing presidency over the last forty years. The transition of power at the presidential level, resulted in across the board transitions with a new Minister of Health being appointed who in turn appointed a new technical team at the Ministry of Health. There is a continuation of key policies in the health sector. Regarding institutional capacity, while Angola does have experience implementing the Municipal Health Services Strengthening Project (P111840), it was nevertheless implemented by a Project Implementation Unit (PIU) outside of the MOH. The proposed project will be overseen by a new team at the MOH. However, the PIU team will support the new MOH team with the fiduciary and implementation activities of the project, which is a positive development for creating institutional capacity, but will require initial capacity building to ensure an understanding of World Bank guidelines and procedures, which increases fiduciary risks. To manage these risks, an apolitical and joint technical team comprised of Ministry of Finance and MOH technical specialists has been designated to coordinate across the project; the established project implementation unit for the MHSS project has been

engaged to support the HSPSP; the Bank continues to work with the MOH to provide guidance on fiduciary procedures; and the MOH has assigned one Director-level staff to coordinate the support provided by the different donors in the health sector.

60. Moderate Risks. **Sector strategies and policies, technical design of the project, and environmental and social risks are all considered to be *moderate* risks.** All sector strategies and policies are in place but a moderate risk remains due to occasional weakness from the MOH in reaching out and effectively communicating with other Government bodies, particularly the MoF, and with donors to ensure a clear understanding of the health sector priorities and strategies. The technical design of the project is considered a moderate risk because the project focuses on strengthening the national regulatory and management capacity of the health sector while complementing it with service delivery at the local level supported by tools and a set of well-proven interventions, virtually all of which are currently implemented in key municipalities in Angola. The PBF will be initially piloted in focus provinces to allow for adjustments before a potential scaling up. Finally, while the project is not expected to have any significant negative environmental impact, the construction and upgrading of the National School of Public Health as well as the healthcare waste handling, treatment, and disposal, could lead to some adverse environmental and social impacts. Efforts under the Municipal Health Services Strengthening Project (P111840) which improved environmental conditions, particularly health waste management practices in key areas will help mitigate the potential impacts. Furthermore, it is anticipated that the proposed project will have considerable positive social impact by targeting some of Angola's most vulnerable areas by improving the quality and availability of health services for the population.

VI. APPRAISAL SUMMARY

A. Economic and Financial (if applicable) Analysis

61. The project activities and financing are expected to contribute to improving the utilization and quality of services provided by the Angola's National Health System. These results would be achieved through the project's strategy of simultaneously supporting local level interventions directly related to the provision of health care services and institutional strengthening measures aimed at supporting the coordinating and stewardship role of the health sector authorities. The former would directly support health facilities to deliver better services, (incentivized institutions, motivated human resources with appropriate management tools). The latter would contribute to improving delivery and quality of health services through the support to system-wide measures such as the strengthening of central level stewardship and management of key inputs such as medicines, human resources, health information for decision-making, and better coordination of services and resource allocation (allocative efficiency). The rationale for public provision lies in the positive long-term effects of improved utilization and quality of health services. There is evidence that links investments in health with economic growth, especially in low- and middle-income countries.[18] Improving utilization and quality of essential health services is critical for building human capital, and is necessary to achieve inclusive and sustainable development. The World Bank's value-added includes the provision of technical guidance on the design of a PBF model; discussion and systematizing of procedures for improving the quality of care; identification of high level academic institutions and centers for the training of staff at all levels of service delivery; implementing South-South exchanges on particular topics to enable the health sector to benefit from international experiences; and opening the dialogue for lines of stable annual funding

[18] Global health 2035: a world converging within a generation. The Lancet. 2013

based on evidence and actual needs . In addition, the World Bank will continue to provide support for the policy dialogue across the health sector.

62. The dual nature of the project's support would impact on the quality of maternal and child care in target provinces, increasing the use of prenatal services and birth deliveries attended by skilled healthcare workers, as well as vaccination coverage and the availability of supplies in healthcare facilities. It would also contribute to improving the efficient use of resources by strengthening coordination, planning, governance and accountability mechanisms at the provincial and municipal levels.

B. Technical

63. **The project is relevant and consistent with the aim of strengthening the performance of the Angola health system**. 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. Furthermore, by introducing the PBF-pilot, this is a first step towards helping to shift the focus from an inputs-based approach to a results approach. A results focus will contribute to improved efficiency and several health system pillars such as governance, quality of health service delivery and health financing (strategic purchasing), particularly in the seven targeted provinces. The project components are complementary and the budget for each component and sub-component is reasonable and balanced.

64. **The project arrangements are based on lessons learned from the implementation experience of current projects in Angola and best practices from an international setting.** The past HAMSET project and current MHSS project both emphasized the need for strong coordination and participation from the local, municipal level, particularly in support of service delivery efforts in the project. This project is informed by PBF projects in other Low and Middle Income Countries in Africa, Asia and Latin America. The integration of the project in public institutions will facilitate the ownership and improve rapidly technical capacities of these institutions (Ministry of Health, Provincial-level Health Directorates, Municipal-level administration).

C. Financial Management

65. **A FM assessment was conducted and this was confirmed and finalized at appraisal mission.** The overall conclusion of this assessment is that that the proposed project's FM arrangements have an overall residual FM risk rating of Substantial as the arrangements (accounting staff and systems, internal control produces, and project external auditors) are not yet in place. The borrower should therefore take appropriate actions to ensure that the proposed FM action planned is implemented satisfactorily within the established deadlines.

66. **The integrated PIU, to be established under the GEPE, will have overall fiduciary responsibility for implementation of this proposed project.** The project FMS, reporting to project director and supported by two finance staff, will have overall responsibility for project FM matters. The appointment of the project FMS should be completed within three months after the project effectiveness as the current PIU handling the FM matters of the ongoing Municipal Health Service Strengthening Project will be providing implementation support of this proposed project. The project FMS will be supported by two accountants to be deployed/recruited to the PIU within four months after the project effectiveness. The Provincial Directorate of Health of each participating provinces will appoint finance staff to handle the project funds to be

transferred to them. The project funds, expenditures, and resources will be accounted for using a computerized accounting software and the basis of accounting will be Financial Reporting under Cash Basis. The disbursements of IBRD funds will be done on report-basis (quarterly interim unaudited financial reports) and this proposed project will make use of advances and direct payment methods for disbursements. However, special commitments and reimbursement methods will also be available for the project.

67. **The PIU/MOH will prepare quarterly interim unaudited financial reports (IUFRs) and provide such reports to the World Bank within 45 days of the end of each calendar quarter.** The project financial statements will be audited annually and the audit report will be submitted to the World Bank no later than six months after the end of each financial year. The overall conclusion of the FM assessment is that the project's FM arrangements have an overall residual FM risk rating of Substantial.

D. Procurement

68. **Procurement procedures.** The Borrowers will carry out procurement under the proposed project in accordance with the World Bank's "Procurement Regulations for IPF Borrowers" (Procurement Regulations) dated July 2016 and revised in November 2017 under the "New Procurement Framework (NPF), and the "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated July 1, 2016, and other provisions stipulated in the Financing Agreements. Further, the 'Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants', dated October 15, 2006, and revised in January 2011, will apply.

69. **Procurement arrangements.** The project will be managed by the Project Implementation Unit (PIU) located within the MOH under the Department of Studies, Planning, and Statistics *(Gabinete de Estudos, Planeamento e Estatística (GEPE)*. The PIU will include procurement responsibilities. The procurement department will transition from the World Bank-funded Municipal Health Service Strengthening (P111840) project and it is made of a senior international procurement specialist supported by a procurement officer and an assistant.

70. **PPSD Summary.** A simplified Project Procurement Strategy for Development (PPSD) has been prepared to define the applicable procurement arrangements and procurement methods during implementation. The procurement of medicines, reagents, hospital equipment, contraceptives will use UN Agencies (UNICEF, UNFPA), while the survey on multiple health indicators (DHS/IIMS) will be conducted by the National Statistics Institute (INE). Otherwise, open competition will be used for procurement of goods and works (RFB) and selection of consultants (QCBS, IC), and limited competition (RFQ) will be used for small value procurement to be supplied from the local market.

71. **Procurement capacity.** While the ministry has limited exposure to Bank procurement procedures, the PIU for the project managed the procurement activities under the of the World Bank-funded Municipal Health Service Strengthening (P111840) project. The capacity assessment of the procurement performance under the previous project shows satisfactory quality and adequate capacity to handle procurement activities under this project. Specific procedures for the project will be detailed in the operation manual of the project, which will be developed under the PPA and approved before effectiveness of the project. The senior procurement specialist will transfer knowledge to the officer and assistant, as well as to other counterpart local staff to be appointed to MOH. A specific subcomponent in component 2 of the project will be designed to support strengthening of governance structures in the MOH in the area of procurement (including strategic procurement as part of Public Financial Management).

72. The **procurement risk** associated with the project in view of the risks indicated above and the MoH experience of previous World Bank-financed projects is **Substantial**.

E. Social (including Safeguards)

73. **OP 4.12 is not triggered for this project** as project financed activities are focused on strategic planning and improving the utilization and quality of health services already offered by the existing health care system and will not require any land acquisition or cause any negative impacts on livelihoods. OP 4.10 has been triggered as a precaution during preparation as San indigenous peoples live in at least two of the provinces in which the project will be implemented (Cuando Cubango and Moxico). A social assessment was conducted which confirmed the presence of San indigenous peoples in the specific project area. Considering this, an Indigenous Peoples Planning Framework (IPPF) was prepared which provides guidance for the implementation of activities under Component 1 and 2. This guidance includes screening criteria, information regarding culturally appropriate participation/consultation and adaptations to ensure that indigenous people will benefit from the improvements in health care services and delivery. The IPPF underwent a process of public consultation and was disclosed via the Government of Angola portal and the Angola Ministry of Health website on December 19, 2017 and the World Bank operations portal on January 9, 2018.

74. **The project will support citizen engagement in the project areas, using and strengthening existing mechanisms.** On May 10, 2010, a Presidential Legislative Decree established the National Council for Social Dialogue *(Conselho Nacional de Concertação Social).* The purpose of the Council is to ensure there is collaboration across the different social categories and to empower them to participate in the development of programs and policies to improve socioeconomic conditions in the country. Specific to the health sector, the Council provides a channel for citizens to provide direct feedback to the Executive Branch of the Government on access, utilization, and quality of services, based on community perceptions. The project can use this existing channel of the National Council for Social Dialogue and review the key communications and feedback tools in place to further support or strengthen them.

75. **In the health sector, citizen engagement mechanisms are established and protected by national law from the national to municipal level.** Presidential and published decrees and laws have been issued that govern directly over the health sector and give voice to citizens. These include the Hospital Management law which establishes the duties, composition, and modus operandi of the Office of the User which is an office established to allow citizens who utilize health services to provide feedback on their use of, access to, and perception of quality of health services provided and received. In May of 2014, the MOH approved the Humanization Program to further gather opinions and suggestions from citizens. Furthermore, the Municipal Administration, established the Municipal Community Counseling Committee, the Municipal Council of Social Coordination, and the Municipal Council of Surveillance that aims to strengthen community participation in local governance, which includes the health sector.

76. **Faith-based organizations in Angola also play a critical role in providing channels in support of citizen engagement.** The Council of Christian Churches in Angola *(Conselho de Igrejas Cristãs em Angola, CICA)* and the Archdiocesan Commission for Justice and Peace of Lubango *(Comissão Arquidiocesana de Justiça e Paz do Lubango, CAJPL)* have been playing an active role in strengthening citizen participation in the area of social services. In June 2017, through a partnership effort, CICA and CAJPL presented the social monitoring reports of the public investment program and the integrated municipal rural development and poverty reduction program for the years 2015 and 2016. The social monitoring reports focused on five methodological steps, namely: mapping, problem identification, prioritization of needs, seasonal calendar and survey. The social

monitoring report covers areas pertinent to the health sector namely focusing on use of and perception of quality of services.

77. **Angola also has a network of National Government Organizations (NGOs) supporting citizen engagement efforts.** These NGOs directly participated in supporting the implementation of activities under the MHSS Project focusing on activities to strengthen the social dialogue. The names of these key NGOs are presented in the table below.

Table 2. NGOs supporting Citizen Engagement activities under MHSS

Province	NGOs
Bengo	CVA - Cruz Vermelha de Angola
Icolo and Bengo	CVA
Malange	CVA, ADRA NACIONAL, AES – Associação Educadores Sociais, CARITAS – Calandula, Cacuso
Lunda Norte	CVA
Moxico	CVA, World Vision
Uige	CVA, Mentor
All provinces, particularly Luanda and Bengo	Caritas, AJPD
All provinces	Conselhos de Concertação Social
All provinces	Comissão Arquidiocesana de Justiça e Paz (CAJP) has worked in partnership with CICA (Conselho das Igrejas Cristãs em Angola).

78. **The project will help strengthen an existing citizen engagement mechanism that will collect patient feedback on their perception of quality of health services and patient satisfaction.** Under sub-component 1.1, the project will support strengthening the "Office of the User" *(Gabinete do Utente)* at the provincial level which has been in place since 2009, and has its expansion stipulated in MOH legislation. The project will help give impetus to expanding the Office of the User at the provincial level and in sensitizing policy-makers on the importance of gathering beneficiary feedback to improve the quality of health services delivered. Under the project, a sample of patients from each health facility will be interviewed periodically to collect perceptions regarding main services offered at each level of care. Civil society organizations that already operate at the local level in Angola, will be involved in the processes of designing and implementing these mechanisms in each of the target provinces. Patient perceptions will be compiled and submitted to Provincial Health Directorates and to the PIU at regular intervals. The implementation of patient feedback in target health posts, centers, and municipal hospitals will be tracked using an intermediate result indicators that is part of the results framework.

79. **In addition to the existing citizen engagement mechanisms, the project will also ensure the PBF pilot also provides a forum for the community to be involved.** The piloting of PBF will have a focus on ensuring service delivery to the community-level. In this line, as part of the design of the PBF pilot, a feedback loop will be established to ensure the community can provide inputs that can inform the design of the pilot and support the implementation. One such example can be the use of a PBF community-based survey tool to define an approach that helps clients provide feedback which in turn can be used to improve services.

F. Environment (including Safeguards)

80. Similar to the previous project, MHS (P111840), this project is classified as Category B, since project investments are expected to only have minor, localized and temporary impacts on the environment. 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 is triggered and an Environmental and Social Management Framework (ESMF) was prepared which provides 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. No land acquisition or impacts on forest or areas of important habitats are expected in this project.

81. This project will continue to finance, under Component 1, the delivery of health services currently supported under the MHSS project which includes a small grant allocation for inputs such as equipment, supplies. Allocation of inputs and medical supplies may lead to an increase in medical waste, which may then exacerbate the already existing environmental issues related to the handling and the disposal of healthcare waste throughout project implementation. Hence, borrower prepared a Healthcare Waste Management Plan (HCWMP) to provide guidance to reduce risks associated with such activities. Both the ESMF and the HCWMP underwent a process of public consultation and were disclosed via the Government of Angola portal, the Angola Ministry of Health website, and the World Bank operations portal on December 8, 2017.

82. Throughout the implementation of the MHSS, the Borrower's capacity to handle and satisfactorily implement environmental safeguard policies has been increasing in the last years and it has now deemed acceptable. The PIU has since designated a dedicated Safeguards Focal Point (SFP) who has been ensuring the project's safeguards requirements are complied with. Notwithstanding, the both the ESMF and the HCWM Plan have made budget provisions for further PIU staff training to adequate, monitor and report project's safeguards performance during implementation.

G. Other Safeguard Policies (if applicable)

83. Not applicable

H. World Bank Grievance Redress

Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit *http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service*. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY : Angola
Angola Health System Performance Strengthening Project (HSPSP)

Project Development Objectives

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

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Percentage of pregnant women who receive four ante-natal care (ANC) consultations		Percentage	0.00	75.00	quarterly	Health facility registration, Provincial Health Directorate database	UCC/MINSA
Number of pregnant women who receive four ANC consultations		Number	0.00	81516.00	quarterly	Health Facility registration, Provincial Health Directorate database	UCC/MINSA
Description:							
Name: Pregnant women who are HIV positive that deliver at a health facility		Number	0.00	2935.00	quarterly	Instituto Nacional de Luta contra SIDA (INLS)	UCC/MINSA

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Pregnant women who deliver at health facilities that are HIV positive and receive ART		Percentage	0.00	60.00	quarterly	INLS	UCC/MINSA
Description:							
Name: Number of consultations conducted through Mobile Health Brigades		Number	0.00	12000.00	quarterly	Provincial Health Directorate	UCC/MINSA
Number of reproductive health consultations conducted through Mobile Health Brigades		Number	0.00	6000.00	quarterly	Provincial Health Directorate	UCC/MINSA
Number of child health consultations conducted through Mobile Health Brigades		Number	0.00	6000.00	quarterly	Provincial Health Directorate	UCC/MINSA
Description:							
Name: Number of health facilities without stock-outs of reproductive health medicines and supplies		Number	0.00	100.00	quarterly	Health Facility registration and Provincial Health Directorate database	UCC/MINSA

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: Indicator considers health centers and municipal hospitals in the target provinces (= 115)							
Name: Number of pregnant women receiving two tetanus vaccines during pregnancy		Number	86456.00	108688.00	quarterly	Health Facility registration and Provincial Health Directorate database	UCC/MINSA
Percentage of pregnant women receiving two tetanus vaccines during pregnancy		Percentage	56.00	60.00	quarterly	Health Facility registration and Provincial Health Directorate database	UCC/MINSA
Description:							

Intermediate Results Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Escolas de Formacao Tecnicas em Saude (EFTS, Technical Health Training Schools) implementing new midwifery training curriculum		Number	0.00	3.00	yearly	Direcçao Nacional de Recursos Humanos (DNRH) and Direcçao Nacional de Saúde Pública (DNSP)	UCC/MINSA

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: There are 19 EFTS nationally and 8 in the project's target provinces.							
Name: EFTS implementing new curriculums (statistics, nursing, laboratory and clinical analysis, and nutrition and diet		Number	0.00	8.00	yearly	Direcçao Nacional de Recursos Humanos (DNRH) and Direcçao Nacional de Saúde Pública (DNSP)	UCC/MINSA
Description: EFTS= Escolas de Formacao Tecnica em Saude - Technical Health Training Schools. There are 19 EFTS nationally and 8 in the project target provinces.							
Name: Development of training curriculum to train nurses on youth-friendly reproductive health services (in-service training)		Yes/No	N	Y	yearly	Direcçao Nacional de Recursos Humanos (DNRH) and Direcçao Nacional de Saúde Pública (DNSP)	UCC/MINSA
Description:							
Name: Nurses trained in youth-friendly reproductive health services		Number	0.00	230.00	yearly	Provincial Health Directorate and Direcçao Nacional de Saúde Pública (DNSP)	UCC/MINSA
Description: Target of 2 nurses per hospital and health post in target provinces.							
Name: Municipalities with		Number	0.00	21.00	yearly	Provincial Health	UCC/MINSA

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
staff trained on the operational and budgetary planning tool (FPOM)						Directorate	
Description:							
Name: Development of a protocol and tool for certifying health posts, health centers, and municipal hospitals		Yes/No	N	Y	yearly	Direcçao Nacional de Recursos Humanos (DNRH) and Direcçao Nacional de Saúde Pública (DNSP)	UCC/MINSA
Description:							
Name: Health units implementing the minimum package of maternal and child health services		Number	0.00	60.00	yearly	Health Facility registration and Provincial Health Directorate database.	UCC/MINSA
Description: The minimum package of services is based on the Maternal and Child Health services package of services and will be defined for each level of health facility (health units, centers, and municipal hospitals)							
Name: Emergency operations center reactivated		Yes/No	N	Y	yearly	Direcçao Nacional de Saúde Pública (DNSP)	MINSA
Description:							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: MICS survey conducted in 2020		Yes/No	N	Y	yearly	Instituto Nacional de Estadística (INE)	MINSA
Description:							
Name: Municipalities implementing operational plans for Health Waste Management		Number	0.00	21.00	yearly	Direcçao Nacional de Saúde Pública (DNSP)	UCC/MINSA
Description:							
Name: Number of health units implementing patient feedback mechanisms and presenting results to the Provincial level		Number	0.00	140.00	quarterly	Provincial Health Directorate	UCC/MINSA
Description:							
Name: Number of health facilities that provide TB diagnosis		Number	0.00	22.00	quarterly	Direcçao Nacional de Saúde Pública (DNSP)	UCC/MINSA
Description: This indicator considers municipal hospitals							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Percentage of female adolescents ages 12-15 that had a family planning consultation		Percentage	0.00	40.00	quarterly	Health Facility registration and Provincial Health Directorate database	UCC/MINSA
Number of female adolescents ages 12-15 that had a family planning consultation		Number	0.00	56441.00	quarterly	Health Facility registration and Provincial Health Directorate database	UCC/MINSA
Description:							
Name: Number of women (ages 15-49) who had a family planning consultation		Number	188032.00	335733.00	quarterly	Health Facility registration and Provincial Health Directorate database	UCC/MINSA
Percentage of women (ages 15-49) who had a family planning consultation		Percentage	23.00	35.00	quarterly	Health Facility registration and Provincial Health Directorate database	UCC/MINSA
Description: Considers 22.77 percent women of child-bearing age.							
Name: People who have received essential health, nutrition, and population (HNP) services	✓	Number	0.00	115000.00	quarterly	Health Facility registration and Provincial Health Directorate database.	UCC/MINSA

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
						Description: The indicator measures the sum of the number of children immunized, the number of women and children who have received basic nutrition services, and the number of deliveries attended by skilled health personnel, through operations supported by the World Bank. The baseline value for this indicator is zero.5 Subsequently, the data should be cumulative—that is, the data in the ISR should represent the cumulative number of people who have received essential HNP services through a Bank-financed project. The cumulative value is added year after year; that is, for Year 1 the value for Year 1 is reported, and for Year 2, Year 1 + Year 2 is reported.	
Number of children immunized	✓	Number	0.00	40000.00	quarterly	Health Facility registration and Provincial Health	UCC/MINSA

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
						Directorate database Description: Children immunized refers to the number of children 5 years of age and younger receiving vaccines purchased through a Bank-financed project, as well as the number of children immunized with vaccines purchased with other resources (i.e., GAVI or government funds) that are delivered through a Bank-supported program. It captures the number of children immunized and not the number of vaccinations; that is, if the same child is immunized with multiple vaccines on the same day or has several immunization visits in a given year, the child is counted only once. Thus simply tallying the monthly totals of the number of children receiving vaccines as recorded in immunization registers or health management information systems leads to double	

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
						counting.	
Number of women and children who have received basic nutrition services	✓	Number	0.00	50000.00	quarterly	Health Facility registration and Provincial Health Directorate database Description: Women and children who have received basic nutrition services refers to the total beneficiaries reached by any of the following services: direct feeding programs (supplementary feeding for pregnant and lactating women and infants and young children under age 5); programs promoting appropriate infant and young child feeding (e.g., promotion/support for exclusive breastfeeding, adequate and timely introduction of complementary foods); nutrition programs for adolescent girls, including nutrition education, micronutrient supplements, etc., delivered through	UCC/MINSA

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
						school health/nutrition programs or other programs reaching adolescent girls; provision of micronutrient supplements to pregnant/lactating women and children under 5 including vitamin A, iodine, iron/iron folic acid, supplemental zinc, and multiple micronutrient powders; food fortification (e.g., iodized salt); deworming; monitoring of nutritional status; nutrition and food hygiene education; nutrition components of early childhood development programs; home gardens and small livestock production for improved dietary diversity; targeted emergency food aid and treatment of severe acute and moderate acute malnutrition. Although the same individuals could receive more than one of the above services, they should be counted only once.	

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Number of deliveries attended by skilled health personnel	✓	Number	0.00	60000.00	quarterly	Health Facility registration and Provincial Health Directorate database Description: Deliveries attended by skilled health personnel refers to the number of women who delivered with the assistance of a skilled health provider (specialist or non-specialist doctor, midwife, nurse, or other health personnel with midwifery skills), whether in health facilities or women's homes. If the Bank-financed activities are mainly at health facilities, the data for this indicator can be obtained from delivery records or health management information systems. If the Bank-financed activities include supporting skilled health providers to provide home deliveries, efforts should be made to accurately record such home deliveries in addition to the institutional	UCC/MINSA

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
						deliveries.	
Percentage of deliveries attended by skilled health personnel		Percentage	55.00	60.00	quarterly	Health Facility registration and Provincial Health Directorate database	UCC/MINSA
Description:							

Target Values

Project Development Objective Indicators

Indicator Name	Baseline	End Target
Percentage of pregnant women who receive four ante-natal care (ANC) consultations	0.00	75.00
Number of pregnant women who receive four ANC consultations	0.00	81516.00
Pregnant women who are HIV positive that deliver at a health facility	0.00	2935.00
Pregnant women who deliver at health facilities that are HIV positive and receive ART	0.00	60.00
Number of consultations conducted through Mobile Health Brigades	0.00	12000.00
Number of reproductive health consultations conducted through Mobile Health Brigades	0.00	6000.00
Number of child health consultations conducted through Mobile Health Brigades	0.00	6000.00
Number of health facilities without stock-outs of reproductive health medicines and supplies	0.00	100.00
Number of pregnant women receiving two tetanus vaccines during pregnancy	86456.00	108688.00
Percentage of pregnant women receiving two tetanus vaccines during pregnancy	56.00	60.00

Intermediate Results Indicators

Indicator Name	Baseline	End Target
Escolas de Formacao Tecnicas em Saude (EFTS, Technical Health Training Schools) implementing new midwifery training curriculum	0.00	3.00

Indicator Name	Baseline	End Target
EFTS implementing new curriculums (statistics, nursing, laboratory and clinical analysis, and nutrition and diet	0.00	8.00
Development of training curriculum to train nurses on youth-friendly reproductive health services (in-service training)	N	Y
Nurses trained in youth-friendly reproductive health services	0.00	230.00
Municipalities with staff trained on the operational and budgetary planning tool (FPOM)	0.00	21.00
Development of a protocol and tool for certifying health posts, health centers, and municipal hospitals	N	Y
Health units implementing the minimum package of maternal and child health services	0.00	60.00
Emergency operations center reactivated	N	Y
MICS survey conducted in 2020	N	Y
Municipalities implementing operational plans for Health Waste Management	0.00	21.00
Number of health units implementing patient feedback mechanisms and presenting results to the Provincial level	0.00	140.00
Number of health facilities that provide TB diagnosis	0.00	22.00
Percentage of female adolescents ages 12-15 that had a family planning consultation	0.00	40.00
Number of female adolescents ages 12-15 that had a family planning consultation	0.00	56441.00
Number of women (ages 15-49) who had a family planning consultation	188032.00	335733.00

Indicator Name	Baseline	End Target
Percentage of women (ages 15-49) who had a family planning consultation	23.00	35.00
People who have received essential health, nutrition, and population (HNP) services	0.00	115000.00
Number of children immunized	0.00	40000.00
Number of women and children who have received basic nutrition services	0.00	50000.00
Number of deliveries attended by skilled health personnel	0.00	60000.00
Percentage of deliveries attended by skilled health personnel	55.00	60.00

ANNEX 1: DETAILED PROJECT DESCRIPTION

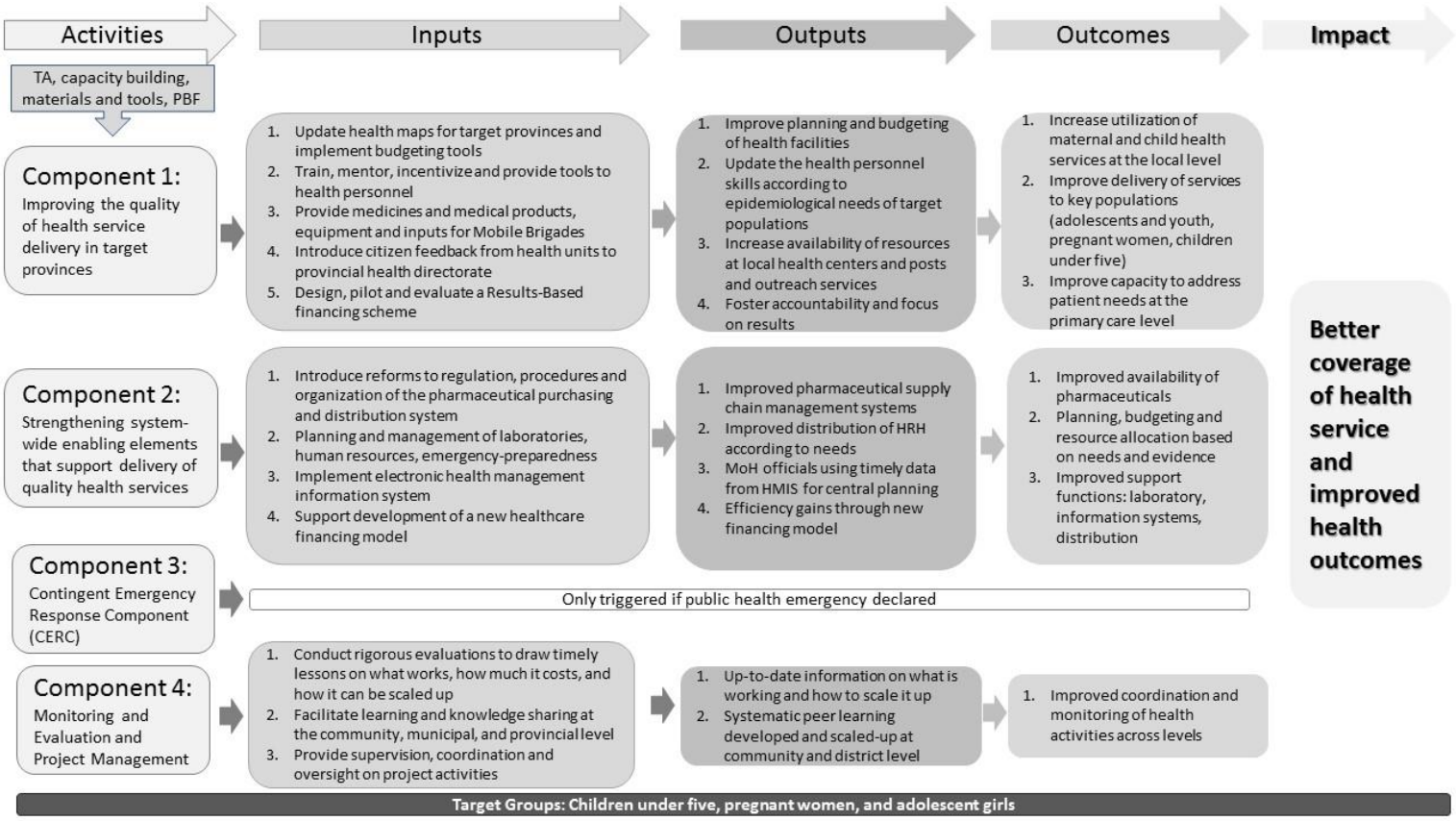
COUNTRY : Angola
Angola Health System Performance Strengthening Project (HSPSP)

84. 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 consider 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.

85. To help address key factors contributing to this challenge, the World Bank and the Government of Angola are preparing a new health project to strengthen the delivery of quality primary health care services at the provincial and municipal level and will further support this by piloting a PBF scheme for health in four municipalities, to incentivize effective healthcare service delivery and progress towards priority health goals. The project will also work on strengthening the MOH capacity to empower it to play a strategic stewardship role in advocating for the health sector across different levels of the system.

86. The project would have four components: (i) improving the quality of health services delivery in target provinces (US$65 million); (ii) strengthening system-wide enabling elements that support delivery of quality health services (US$35 million); (iii) supporting the capacity to respond and prevent public health emergencies (US$0); and (iv) project management and monitoring and evaluation (US$10 million). The project would be implemented over a five-year period from 2018 to 2023.

Figure 3. Project Theory of Change



87. The Project Development Objective (PDO) is to increase the utilization and the quality of health care services in target provinces and municipalities. Given Angola's underperformance in maternal and child health outcomes, the Project will work to increase the utilization and quality of a package of essencial 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 main interventions supported by the Project are listed in Figure 4.

Figure 4: Continuum of reproductive, maternal and child health care services

Reproductive Health	Maternal Health	Neonatal Health	Infant Health	Adolescent Health
HEALTH INFORMATION AND HEALTH EDUCATION GENDER EQUALITY PREVENTION OF MATERNAL AND NEONATAL DEATHS				
• Wellbeing of the reproductive systems • Reproductive health information • Safe and satisfactory sexual life • Informed decision making on reproductive health choices • Healthy timing and spacing of pregnancies • Prevention of sexually transmitted infections • Involvement of men in reproductive health	• Prenatal care • Nutrient supplementation (iron, folic acid, vitamin A) • Vaccinations • Institutional delivery • Emergency obstetric care • Family planning • Intermittent preventive malaria treatment in pregnancy • HIV testing and counseling • Prevention of mother-to-child transmission of HIV • Prevention of sexually transmitted infections • Treatment of other underlying conditions	**Integrated Management of Neonatal Illnesses** • Emergency neonatal care • Post-natal care consultations • Exclusive breastfeeding through the sixth month • Vaccinations • Prevention of mother-to-child transmission of HIV (antiretroviral therapy) • Treatment of infections and other underlying illnesses	**Integrated Management of Childhood Illnesses** • Vaccination • Oral rehydration therapy • Deworming • Vitamin A supplementation • Growth monitoring and nutritional counselling • Prevention of mother-to-child transmission of HIV • Treatment of underlying illnesses	**Youth Friendly Reproductive Health Services** • Barrier methods • Modern contraceptive methods • Healthy timing and spacing of pregnancies • Prevention, testing, and treatment of sexually transmitted infections • HIV counseling and testing • Antiretroviral therapy • Involvement of adolescent men and youth

88. 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, emergency obstetric and neonatal care. 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.

89. Component 1 – Improving the Quality of Health Services Delivery in Target Provinces (US$65 million). This component will 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 four municipalities in two different provinces.

90. Sub-component 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 services delivered at the provincial and municipal level. The criteria to be used for the selection of target provinces will be based on (i) the provinces and municipalities covered under the current Municipal Health Services Strengthening Project (MHSS-P111840), and (ii) additional provinces and municipalities based on the following criteria: population to be reached, accessibility, availability of infrastructure, and population density as a proxy for poverty. In applying these criteria, the following provinces and municipalities will be the target intervention areas which represent 3.8 million people (13.5 percent of the country's total population).

- Bengo: Ambriz and Dande
- Luanda: Icolo e Bengo
- Lunda Norte: Chitato, Cambulo, Cuango, Lucapa
- Malanje: Cacuso, Calandula, Malanje, Caculama
- Moxico: Camanongue, Luau, Luena (Moxico)
- Uige: Maquela do Zombo, Negage, Sanza Pombo, Uige
- Cuando Cubango: Cuito Cuanavale, Mavinga, Menongue

91. Sub-component 1.1 will focus on improving the quality of health services delivered at the provincial and municipal level. This sub-component will continue to finance the delivery of health services currently supported under the MHSS project. To complement service delivery, this sub-component will also support key actions to strengthen local governance of the health system. Sub-component 1.1 will finance the following activities in the project's target provinces and municipalities:

Consultancies:
- Analysis for the creation of a hospital waste management system
- A diagnostic of the priority needs
- Develop or update the health maps ("mapas sanitarios") as needed

Goods:
- Pharmaceutical products and vaccines; tests for priority diseases such as HIV/sexually transmitted diseases, malaria and dengue among others; nutritional products; family planning medicines and medical products.
- Equipment and supplies for delivery rooms and to support reproductive health service delivery
- Cold-chain equipment
- Blood Banks and reagents for blood banks
- Vehicles
- Equipment for the hospital waste management system

Operating costs
- Expenses related to the mobilization of the mobile health brigades
- Expenses related to supporting the mobilization of health workers

Training costs
- Training on public health programs and their operational plans
- Training-of-trainers for the updating the *mapas sanitarios*
- Training of health workers on Integrated Management of Neonatal and Childhood Illness (IMNCI) and Emergency Maternal Obstetric Neonatal Care (EMONC).

92. Subcomponent 1.2. Piloting Performance-Based Financing (US$20 million). The Performance Based Financing (PBF) pilot will support health service delivery through a performance focus adjusted for the provincial and municipal level context. 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 province and municipality and proposes to set aside a percentage of the transfer to be used for the payment for performance at different levels of the health system. This percentage will be paid based upon the achievement of targets in the interventions selected to be incentivized. As part of the contracting scheme, contract management skills will need to be developed and strengthened in both ministries. The MOH will work with the MoF to: (i) develop and manage the contracts are to be entered into by the provinces/municipalities with the MOH documenting the targets to be achieved across the selected intervention areas; (ii) define the reporting periodicity and sources of information for assessing the achievement of the targets; (iii) review the results reported and confirm the achievement or not; and (iv) provide MoF with the validated results against which payment can be made. The PBF pilot aims at : (i) demonstrating that the contracting mechanism creates the enable environment for positive behavior change for health workers which leads to increased productivity in quantity and quality of services); and (ii) identifying and supporting the institutional changes needed for the contracting mechanism to be developed within the framework of the national budget in order to reduce inefficiencies in spending and increase financial accountability of actors at different levels of the health care system. The MOH would like to pilot the PBF scheme in four provinces within two provinces. 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. Sub-component 1.2 will finance the following activities:

Consultancies:

- Design of the instruments needed to roll-out the PBF pilot scheme
- Analysis to determine the quantity and financial transfer arrangements
- Design and implementation of systems for collecting, consolidating, and calculating the results achieved through the PBF scheme

Goods:

- Information technology equipment for the municipalities where the PBF scheme will be piloted
- Equipment and supplies for the health care facilities where the PBF scheme will be piloted

Operating Costs:

- Financial stipends and incentives for health personnel supporting the implementation of the PBF scheme
- Financial transfers to the Municipal health care facilities based on the results achieved

Training:

- Training on the roll-out and implementation of the PBF pilot
- Training on the use of the PBF instruments

93. Component 2 – Strengthening system-wide enabling elements that support delivery of quality health services (US$35 million). This component aims to support institutional strengthening across the national health system towards improving the financing, quality and coordination of health care services delivered at the municipal, provincial, and national levels. The component will therefore contribute to reducing health system inefficiencies -- a critical effort given the country's limited availability of resources. Activities in Component

2 will support the development of a new financing model and structure for the sector, the strengthening of data collection and use for improved evidence-based decision-making, the implementation of normative instruments and regulations for the health sector, and the updating and development of national policies and plans for human resources for health. Component 2 will also support the broader reform agenda of the MOH to address system bottlenecks to improve health outcomes. The component will assist the sector in improving its overall coordination and strengthen the stewardship role of the MOH for a more effective and better quality frontline service delivery.

94. Accordingly, Component 2 will provide support to 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). Component 2 will finance the following activities:

Civil works:

- Rehabilitation of the national reference laboratory (level 4 laboratory) and the country's laboratory network
- Modular construction and rehabilitation of the National School of Public Health

Consultancies:

- Analysis of the needs of the country's network of laboratories and their sustainability
- Analysis, supervision, and monitoring of the ADECOS program
- A review of the national Human Resources for Health (HRH) Policy and HRH Development Plan and their updating and approval
- Expanding the use of the HRH data-base at a national-level with a view to creating a national HRH observatory
- Analysis for the construction and rehabilitation of the National School of Public Health
- Development of the curriculums for the National School of Public Health
- Implementation of the new curricula at the Health Technical Schools
- Development of in-service training curriculum for youth friendly reproductive health services
- Create the norms and structure for the Emergency Program and Emergency Center
- Development of instruments for the certification of health facilities
- Evaluations and development of training modules to support implementation of the health management information system
- Development of an IIMS/DHS survey and of an SDI Survey
- Updating the National Health Accounts, including operational costs
- Analysis of the health sector investment needs in a medium to long-term vision
- Development of a new financing model structure and its implementation strategy
- Compatibilization of the tools developed to support the preparation of the annual operational plans and budgeting at the municipal, provincial, and hospital levels.

- Development of the norms and guidelines for creating a vaccine fund
- Development of a new drug supply chain management structure and logistics
- Development of an application for the control and management of medication and vaccines
- Analysis of the price and margins regulations for the sales of pharmaceutical products
- Inventory of the traditional medicines in Angola
- Review of the registering and procedures related to the procurement of essential medicines and devices and other medical supplies
- Design a concept and implementation plan for the registration of medicines

Goods:

- Equipment and supplies for the national reference (level 4) laboratory and for the country's network of laboratories
- Equipment and supplies for the National School of Public Health
- Purchase of equipment and supplies for the Emergency Center and Program
- Purchase of information technology equipment and material including software and audio visual equipment to support the health management information system, the new health financing model and pharmaceutical management
- Produce documentation related to the certification of health facilities
- Produce documentation related to the normative documents produced with EU and World Bank financing

Operating costs:

- Establish the initial financing for the vaccine fund
- Support for scaling up the implementation of a new health management information system

Training:

- Training of laboratory technicians
- Training of health workers to support them in applying normative instruments in management, follow-up, supervision, and maternal and child health control.
- Training of health workers on how to apply the revised and updated manuals on the municipalization of health services
- Training at the Health Technical Schools on how to implement the newly developed curricula (statistics, nursing, laboratory and clinical analysis, and nutrition and diet) and on midwifery specialization
- Training of health professionals on youth friendly health services
- Annual conference on the municipalization of health services
- Training on the normative documents produced for the Angola health sector through the financing of other development partners
- Training on use of new tools for the health management information system and logistics management and information system
- Workshop on the new Health Financing model
- Training-of-trainers on the use of tools developed to support the development of the annual operational plans and of budget management at the municipal, provincial, and hospital-levels
- South-to-South exchange on international experiences on the regulation of pharmaceutical products and drug supply management.

95. 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 enable the 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.

96. 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). Component 2 will finance the following activities:

Consultancies:

- Consultants to support the MOH Project Implementation Unit (PIU)

Operating Costs:

- Participation of MOH PIU staff and consultants in conferences and workshops related to project technical areas and implementation
- Logistical support (transport) to trainers, coordinators, certifiers to conduct field visits to provinces, municipalities, and comunas
- Logistical support (per diem) to trainers, coordinators, certifiers to conduct field visits to provinces, municipalities, and comunas

Training:

- Participation of MOH PIU staff and consultants in capacity-building activities related to project technical areas and implementation.

ANNEX 2: IMPLEMENTATION ARRANGEMENTS

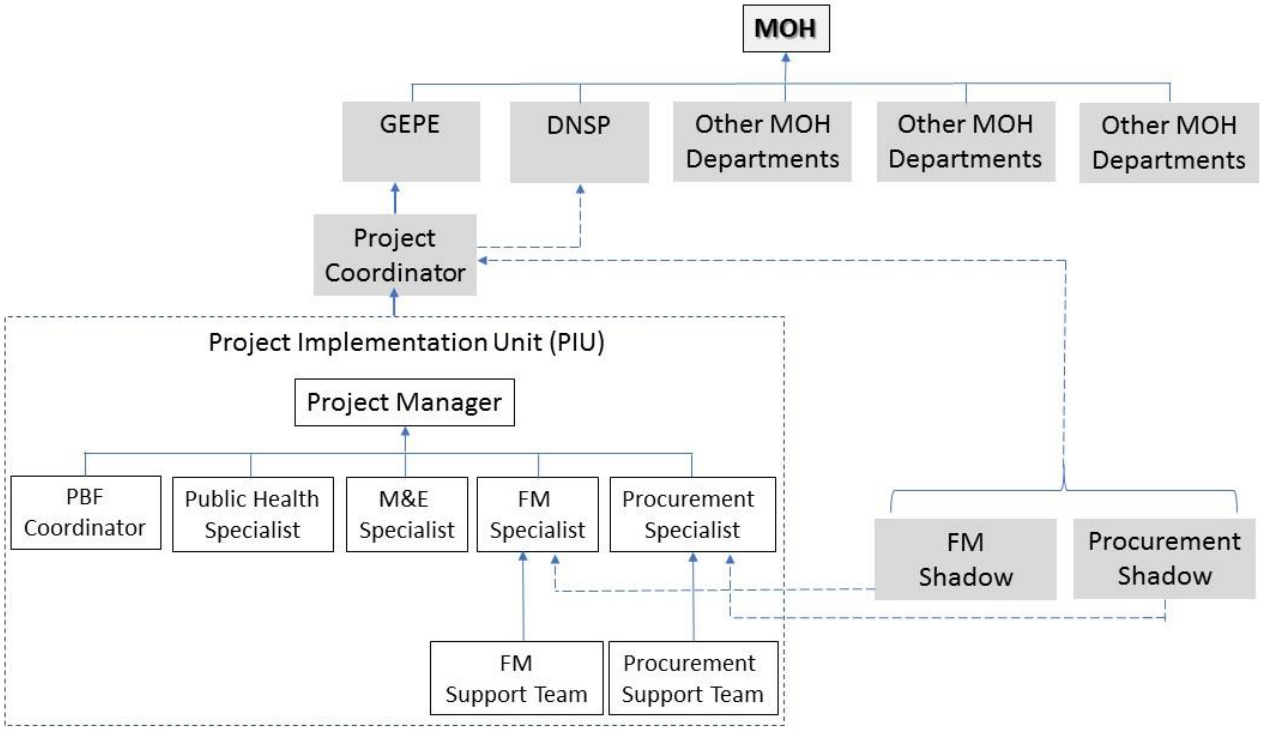
COUNTRY : Angola
Angola Health System Performance Strengthening Project (HSPSP)

Project Institutional and Implementation Arrangements

97. 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.

98. 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. The figure below provides a visual overview of the MOH structure that will support and implement the project.

Figure 5. Institutional Arrangements



99. The risk for the implementation of the project is Substantial. Acceptable project FM arrangements are in place and will contribute to building this capacity within the Ministry across the life of the project. The project will follow the Bank's New Procurement Policy and the New Procurement Framework (NPF). A Project Procurement Strategy for Development (PPSD) has been completed with the Bank procurement team's support and guidance.

100. 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 five 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 facilitate payment of activities at provincial and local 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.

Financial Management and Disbursements

101. **Summary**. A Financial Management (FM) assessment was carried out in accordance with IPF Directive and Policy, and the Financial Management Manual for World Bank IPF Operations issued by the FM Sector Board on March 1, 2010, and last reviewed on February 10, 2017. The objective of this assessment was to determine whether the proposed implementing agency, the Ministry of Health (MOH), has acceptable FM arrangements

for the implementation of the proposed project. The arrangements are considered acceptable if the entities' planning, budgeting, accounting, internal controls, funds flow, financial reporting, and auditing arrangements (a) are capable of correctly and completely recording all transactions and balances relating to the project; (b) facilitate the preparation of regular, timely, and reliable financial statements; (c) safeguard the project's assets; and (d) are subject to auditing arrangements acceptable to the World Bank.

102. The overall conclusion of the FM assessment is that the proposed project's FM arrangements have an overall residual FM risk rating of Substantial as the arrangements (accounting staff and systems, internal control produces, and project external auditors) are not yet in place. However, the current PIU handling the FM matters of the ongoing Municipal Health Service Strengthening Project will provide support for the implementation of this proposed project. Therefore, the MOH should take appropriate actions to ensure that the FM action plan is satisfactorily implemented within the deadlines as stipulated in the action matrix to ensure that acceptable project control environment is maintained throughout its implementation.

103. **Strengths**. The project FM will be implemented by an integrated PIU to be established under the GEPE. The Ministry of Health through the established PIU is implementing the ongoing Municipal Health Services Strengthening Project (MHSS) and this PIU will provide support to implementation of the proposed project

104. **Weaknesses**. While the project fiduciary matters will be handled by a PIU under the GEPE, the proposed project FM arrangements and system are not yet in place and there may be some delays in putting in place adequate FM arrangements.

105. **Budgeting**. The PIU will prepare annual budgets based on the annual work plans and the approved procurement plan. Activities for the various components were discussed and confirmed during the negotiation phase of the project. It is expected that the PIU will prepare annual budgets that cover activities proposed to be carried out in each fiscal year. The project will also be responsible for producing variance analysis reports comparing planned with actual expenditures on a quarterly basis. The periodic variance analysis will enable the timely identification of deviations from the budget. These quarterly variance analysis reports will be part of the IUFRs that will be submitted to the World Bank on a quarterly basis. The budget preparation and monitoring of budget execution will be described in the Financial Management Manual, and formats for annual budget and monitoring reports will be included as annexes.

106. **Staffing**. The PIU under the GEPE will be responsible for fiduciary aspects of the project. PIU FM capacity will comprise a project Financial Management Specialist (FMS) and two finance staff. The overall responsibility of project FM matters rests with the project FMS reporting to the project director. The project FMS should be appointed within three months after the project effectiveness and he/she should be qualified and experience in managing World Bank and/or donor-funded projects. The FM team of the ongoing Municipal Health Service Strengthening Project will provide support to the implementation of this proposed project until the recruitment/deployment of FM staff for this proposed project. The two project finance staff should be deployed/recruited to the PIU within four months after the effectiveness date. The fees of the project FMS will be funded by the project proceeds. The Provincial Directorate of Health of each participating province will appoint finance staff (preferably those handling the decentralized funds of the ongoing MHSS) to take the responsibility of managing project funds channeled to the provinces to finance project activities at local levels. The appointed finance staff at each Provincial Directorate of Health will manage the funds under the supervision and guidance of the project FMS. In addition, those finance staff will be training in management of decentralized project funds before the funds are channeled to the provinces.

107. **Accounting**. The implementing agency will account for all project funds, expenditures, and resources using a computerized accounting software and the basis of accounting will be financial reporting under cash basis. The computerized accounting package will be purchased and installed within four months after the effectiveness date. Throughout project implementation, the implementing agency should maintain a sound computerized accounting software that enables key controls, records project transactions correctly, and can produce timely and reliable financial information.

108. **Internal control**. The Inspectorate General of Finance (Inspecção Geral das Finanças), based at the Ministry of Finance, is responsible for the internal audit functions across the entire government. However, the inspectorate general of finance has limited capacity, and therefore, the project may not benefit from its review of this operation. Hence, regular supervision through desk review and field visits should be carried out by the World Bank to ensure that the PIU is maintaining adequate systems of internal controls and key procedures are complied with.

109. The finance and administrative procedures to be employed by the implementing agency will be documented in the project FM Manual to be finalized and adopted no later than four months after effectiveness. This manual will cover at least the following aspects: institutional arrangements, budget and budgetary control, disbursement procedures and banking arrangements, receipt of goods and payment of invoices, internal control procedures, accounting system and transaction records, reporting requirement, and audit arrangement. The manual will also include guidance for funds flow and payments related to the PBF scheme. In addition, guidelines will be prepared to document procedures for utilization of project funds at provincial and local levels, including the financial reporting.

110. **Financial reporting**. The PIU will prepare quarterly IUFRs for the project, in form and content satisfactory to the World Bank, which will be submitted to the World Bank within 45 days after the end of the calendar quarter to which they relate. These reports should provide financial information required to effectively monitor and manage the project. The contents of these reports should consist of financial reports, including all sources and uses of funds reports by project components and categories, and uses of funds by project components and activities (including comparison of budget and actual expenditures)

111. The PIU will also produce annual project financial statements, which will comprise:

(a) a statement of sources and uses of funds/cash receipts and payments, which recognizes all cash receipts, cash payments, and cash balances controlled by the entity for this project and separately identifies payments by third parties on behalf of the agency;

(b) the statement of uses of funds by project components and activities, including comparison of budget and actual project expenditures;

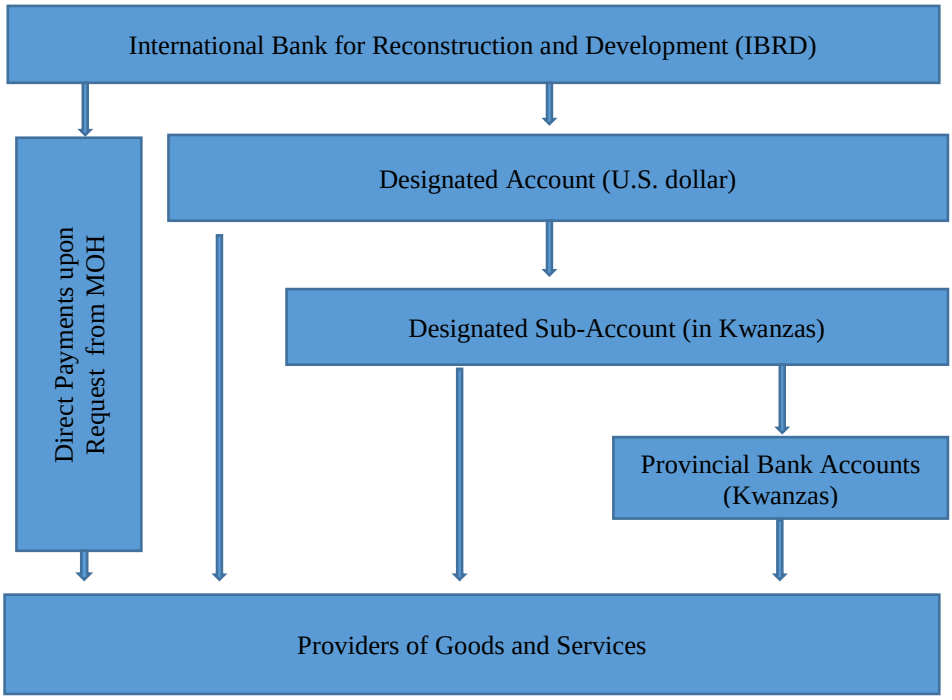
(c) the accounting policies adopted and explanatory notes. The explanatory notes should be presented in a systematic manner with items on statement of cash receipts and payments being cross-referenced to any related information in the notes. Examples of this information include a summary of fixed assets by category of assets; and

(d) a management assertion that IBRD funds have been expended in accordance with the intended purposes as specified in the relevant World Bank Legal Agreement.

112. **Flow of Funds**. To facilitate the implementation of the project activities, the MOH will establish and maintain a segregated Designated Account (DA) in U.S. dollars at the commercial bank under terms and

conditions acceptable to IBRD. Funds in the DA will be used to finance eligible project expenditures in accordance with the Loan Agreement and Disbursement Letter. From the DA, the PIU will: (i) make payments for foreign consultants and suppliers of goods and services; (ii) transfer funds to the DA sub-account in local currency to facilitate payments of local eligible project expenditures and transfer funds to separate provincial bank accounts (to facilitate payments of eligible project expenditures to be incurred at provincial and local levels). The figure below depicts the funds flow mechanism for the project activities to be financed under the traditional disbursement methods.

Figure 6. Flow of Funds Mechanism



113. **Disbursement arrangements**. Disbursement of IBRD funds will be report-based (quarterly interim unaudited financial reports). These reports will include a statement of sources and uses of funds, an updated six-month forecast, Designated Account Activity statement and statements of eligible expenditure under contracts subject to and not subject to prior review.

114. An initial advance will be made into the Designated Account upon the effectiveness of the Loan Agreement and at the request of MOH/PIU. The advances will be the estimated cash requirements to meet the project expenditure for first 6 months of the project life, as indicated in the initial six-month cash flow forecast. After every subsequent quarter, MOH/PIU will submit the IUFRs. And, the cash requests at the reporting date will be the amount required for the forecast period as shown in the approved IUFRs less the balances in the Designated Account at the end of the quarter.

115. The option of disbursing the funds through direct payments from IBRD on contracts above a pre-determined threshold will also be available. The reimbursement and special commitments disbursement methods will be also available. The Bank will issue the Disbursement Letter that will specify additional instructions for withdrawal of the proceeds of the Loan.

116. **Disbursements under piloting Performance-Based Financing (PBF).** Up to US$20 million of the Project proceeds are earmarked for PBF, and confirmation of the achievement of the targets will be based on agreed verifiable indicators. Once the achievement of an indicator is verified, the Government can make a disbursement request. The Project Operational Manual will document in detail the financial management and disbursements arrangements for the result based-financing component. This will include verification mechanisms. In order to conduct the verification of indicators, the PIU will be responsible for compiling all data, information and evidence of the achievement of the targets. The contents and quality of verification must be satisfactory to IBRD. The targets in the interventions selected to be incentivized has been discussed and confirm during the appraisal mission. The payments under the result based-financing component will be done on quarterly basis from the Designated Account or the separate bank accounts to be maintained and managed by the Provincial Directorate of Health.

117. **Auditing**. The project financial statements will be audited annually in accordance with International Standards on Auditing as issued by the International Auditing and Assurance Standards Board (IAASB), and the audit report together with management letter will be submitted to the World Bank within six months after the financial year-end, that is, June 30 of each following fiscal year. The costs incurred for the audit will be financed under the project. The auditors will be required to express a single opinion on the project financial statements. In addition, a detailed management letter containing the auditor's assessment of the internal controls, accounting system and compliance with financial covenants in the Loan Agreement, suggestions for improvement, and management's response to the auditor's management letter will be prepared and submitted to management for follow-up actions. The arrangements for the appointment of the external auditors of the project financial statements will be communicated to the World Bank through agreed terms of reference. The terms of reference of the project's external auditor will be finalized following effectiveness to enable the commencement of the procurement of external audit services, and this should be completed within four months after the project effective date. The project will comply with the World Bank disclosure policy on audit reports (for example, make publicly available, promptly after receipt of all final financial audit reports and place the information provided on the official website within one month of the report being accepted as final by the World Bank).

118. **Effectiveness condition**. There is no FM condition for effectiveness of this project.

119. **Dated covenants**. Appointment of the project FMS within three months after the project effective date. Within four months after the project effective day, the MOH should: (i) Deploy/recruit two finance staff to the PIU; (ii) prepare and adopt the project Financial Management Manual, including guidelines for the provinces; (iii) purchase and install computerized accounting software; (iv) and appoint project external auditors.

120. **FM action plan**. To establish an acceptable control environment and to mitigate FM risks, the following measures should be taken by the due dates indicated in the FM action plan below.

Table 3. FM Action Plan

No.	Action	Responsibility	Completion date
1	Appointment of a qualified and experienced project FMS	MOH	No later than three months after effectiveness

No.	Action	Responsibility	Completion date
2	Deployment/recruitment of two project finance assistants to the PIU	MOH	No later than four months after effectiveness
3	Preparation and adoption of project FM Manual (including a guideline for provinces) acceptable in form and substance to the World Bank	MOH	No later than four months after effectiveness
4	Training of Provincial Directorate of Health finance staff who will handle project funds at the provincial level	MOH	No later than four months after effectiveness
5	Purchase and installation of computerized accounting software for the project	MOH	No later than four months after effectiveness
6	Appointment of the project and external auditors	MOH	No later than four months after effectiveness

121. **Supervision plan**. The project will be supervised on a risk-based approach. The FM supervision will be carried out by the World Bank FM Specialist. These supervisions will focus on the status of the FM system to verify whether the PIU/MOH continue to maintain acceptable project FM arrangements and provide support where needed. The initial supervision will focus on review of implementation progress of the agreed FM action plan. The FM supervision missions will also include a review of quarterly progress reports and audit reports and follow up on material accountability issues by engaging with the task team leader (TTL), client, and/or auditors. Based on the assessment, the PFM current risk is Substantial and field visit supervision will be twice during the fiscal year and adjust when the need arises.

122. **FM risk assessment and mitigation**. The World Bank's principal concern is to ensure that the project funds are used economically and efficiently for the intended purpose. Assessment of the risks that the project funds will not be appropriately used is an important part of the FM assessment work. The risk features comprise two elements: (a) the risk associated to the project as a whole (inherent risk) and (b) the risk linked to a weak control environment with regard to the project implementation (control risk). The content of these risks is described in the table below.

Table 4. PFM Risk Assessment and Mitigation Measures

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Yes/No)	Residual Risk
Inherent risk	**S**	—	—	**S**
Country level. Progress has been made in reform of the country's PFM over the years; however, these reform efforts are yet to address weaknesses in the budget execution, internal controls, capacity development, and general oversight.	H	The GoA is committed to continue with implementation of PFM reform to improve the control environment country national systems. The PEMFAR is under way and draft reports acknowledge the commitment by the Government to reform the country's PFMs over the years, and the progress made.	No	H
Entity level. The MOH may not be able to meet the FM requirements for Bank-financed projects due to weak FM capacity.	S	The MOH will recruit a qualified and experienced project FMS to ensure the appropriate management of the project funds and train Ministry's finance staff to be deployed to the project. The Financial Management Manual will be produced and adopted for the project.	No	S
Project level. The MOH may fail to ensure an acceptable project FM environment, especially at the provincial due to a lack of FM capacity.	S	Qualified and experienced project FMS with the support of two finance staff will handle project FM matters. Project FM Manual and guidelines will be prepared and adopted by MOH for project implementation.	No	S
Control Risk	**S**			**S**
Budgeting. Weak budgetary execution monitoring may lead to budgetary overruns or inappropriate use of project funds	M	The Financial Management Manual will spell out the budgeting and budgetary control arrangements to ensure appropriate budgetary oversight. The IUFR will include a comparison of planned and actual project expenditures.	No	M

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Yes/No)	Residual Risk
Accounting. The project accounting function might not be able to execute its duties and to generate timely financial information.	S	The MOH will recruit a suitably qualified and experienced project FMS to ensure appropriate performance of the accounting and FM functions. A computerized accounting software will be purchased and installed within four months after the project effectiveness.	No	S
Internal control. The risk of noncompliance with key internal control procedures due to weak FM capacity, especially at provincial level	S	Financial and administrative procedures to be employed by the PIU/MOH in project implementation will be documented in the Financial Management Manual. The World Bank's regular FM implementation support through desk reviews and field visits will make appropriate recommendations to improve project FM environment.	No	S
Funds flow. Funds will be channeled from the DA to some participating provinces, therefore, there is a risk that project funds may not be used for intended purposes.	S	Internal control mechanism for transfer of funds from the DA to the participating provinces will be documented in the Financial Management Manual to be prepared and adopted by the project. The participating provinces' finance staff who will be managing project funds will be trained for management of decentralized project funds.	No	S
Financial reporting. The project may not be able to produce the financial reports required on time, as required for project monitoring and management.	M	The MOH will recruit a project FMS appropriately experienced in financial reporting and conversant with the related World Bank or other donors project financial reporting requirements. The PIU/MOH will use computerized accounting system that will enable the efficient and timely generation of financial information.	No	M

Risk	Risk Rating	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Yes/No)	Residual Risk
Auditing. Delays in submission of audit reports or delays in implementing the recommendations of the management letter	M	An independent external audit firm will be hired by the project to ensure compliance with the audit submission timelines set out in the Loan Agreement. The World Bank will monitor audit submission compliance and ensure implementation of management letter recommendations.	No	M
Governance and accountability. Possibility of corrupt practices, including bribes, abuse of administrative and political positions, misprocurement and misuse of funds are a critical issue.	S	Project FM arrangements (including annually audit of project accounts and World Bank FM supervision including review of transactions and asset verification) designed to mitigate the fiduciary risks in addition to the PIU overall internal control systems.	—	S
OVERALL FM RISK	**S**	—	—	**S**

Note: M = Moderate; S = Substantial.

123. The overall residual FM risk rating is deemed Substantial as the proposed project arrangements are not yet in place (accounting staff and systems, internal control procedures, and project external auditors). The mitigations measures include appointment of qualified and experienced project FMS; deployment of two project finance staff; adoption of project Financial Management Manual; purchase and installation of computerized accounting software; and appointment of project external auditors within four months after the effective date.

Procurement

124. **Applicable procedures.** The Borrowers will carry out procurement under the proposed project in accordance with the World Bank's "Procurement Regulations for IPF Borrowers" (Procurement Regulations) dated July 2016 and revised in November 2017 under the "New Procurement Framework (NPF), and the "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants", dated July 1, 2016, and other provisions stipulated in the Financing Agreements.

125. **Procurement strategy.** A simplified Project Procurement Strategy for Development (PPSD) has been prepared to define the applicable procurement arrangements and procurement methods during implementation. The outcome of the PPSD is the Procurement Plan prepared and which, following negotiations, was recorded by the borrower in the World Bank's Systematic Tracking of Exchanges in Procurement (STEP).

126. **Procurement arrangements.** The project will be managed by the Project Implementation Unit (PIU) located within the MOH under the Department of Studies, Planning, and Statistics *(Gabinete de Estudos, Planeamento e Estatística (GEPE)*. The PIU will have procurement responsibilities. The procurement

department will transition from the World Bank-funded Municipal Health Service Strengthening (P111840) project and it is made of a senior international procurement specialist supported by a procurement officer and an assistant.

127. **Procedures for selection of consultants**. Quality and Cost-Based Selection will be the main method for the selection of firms for (a) Supervision of construction works of the Public Health National School, (b) the Survey of service delivery (SDI) and (c) the Development of an application for medicine and vaccination control. Other consultancies will be sourced to individual consultants, such as the staff for the project implementation unit, definition and implementation of the medicine registry, diagnostic of targeted provinces, development of syllabus of the national health school. Occasionally, consulting services may be procured through Consultants Qualifications based Selection (CQS).

128. **Procedures for Goods, Non-Consulting Services and Works.** Open competition will be the main approach, through request for bids for goods (equipment for emergency centers, equipment and furniture for the public health national school, some reagents, printing of documents) and for works (construction of the Public Health National School and the rehabilitation of the laboratory level 4). UN Agencies, such as UNICEF and UNFPA will be the main suppliers of medicines, some medical equipment, reagents and contraceptives. Smaller purchases that can be supplied from national suppliers will be procured through the Request for Quotations. The survey on multiple health indicators (DHS/IIMS) will be conducted by the National Statistics Institute (INE), the sole institution allowed, by law, to perform such survey in the country.

129. **The Procurement Plan** will be managed through the World Bank's tracking system, STEP.

130. **Review by the World Bank of procurement decisions.** The Table below indicates the initial values for prior review by the World Bank. All activities estimated to cost below these amounts shall be treated as post review and will be reviewed by the World Bank during the Implementation Support Mission under a Post Procurement Review exercise. Direct Contracting/Single Source will be subject to prior review only above the amounts given in the table. The World Bank may, from time to time, review the review amounts based on the performance of the implementing agencies.

Table 5. Prior Review Thresholds

Procurement Type	Prior Review (US$)
Works	5,000,000
Goods and Non-Consulting Services	1,5000,000
Consultants (Firms)	500,000
Individual Consultants	200,000

131. **Assessment of national procedures.** The Angola Procurement Regulation, the Law nº. 9/16 of June 16, has been assessed as required under the World Bank's Procurement Framework. The assessment indicated that the Country's Regulations are generally consistent with international best practice, although some weaknesses were identified, which should be mitigated with adequate measures: (a) there is adequate advertising in national media; (b) the procurement is generally open to eligible firms from any country; (c) contracts documents have an appropriate allocation of responsibilities, risks, and liabilities; (d) publication

of contract award is generally not done (but the PIU of the project has a good record of contract publications); (e) the national regulations do not preclude the World Bank from its rights to review procurement documentation and activities under the financing; (f) claims are decided at the procuring entity level for administrative complaints but there is possibility of appeal to the court; and (g) maintenance of records of the procurement process needs improvement overall but the Ministry of Health, and the PIU of the project in particular, has a good filing system of procurement processes.

132. The request for bids/request for proposals document shall require that bidders/proposers submitting bids/proposals present a signed acceptance at the time of bidding, to be incorporated in any resulting contracts, confirming application of, and compliance with, the World Bank's Anti-Corruption Guidelines, including without limitation the World Bank's right to sanction and the Bank's inspection and audit rights.

133. With the incorporation of the above provision, the Angola Procurement Regulation will be acceptable to be used under those procurements not subject to the World Bank's Prior Review, as the thresholds indicated in Table 5, or any updates indicated by the World Bank in the Procurement Plan.

Environmental and Social (including safeguards)

134. Throughout the implementation of the MHSS, the Borrower's capacity to handle and satisfactorily implement environmental safeguard policies has been increasing in the last years and it has now been deemed acceptable. The PIU has since designated a dedicated Safeguards Focal Point (SFP) who has been ensuring that project's safeguards requirements are complied with. Notwithstanding, both the SMF and the HCWMP have made budget provisions for further PIU staff training to adequately monitor and report project's safeguards performance during implementation.

Monitoring and Evaluation

135. The PIU will include a Monitoring and Evaluation (M&E) specialist who will be selected from within the MOH and who will report directly to the Project Director. This is in line with the two-fold approach of the overall project implementation arrangements to build capacity within the MOH by housing the project within the MOH and to designate MOH staff to take on key PIU functions, as opposed to relying on international consultants to fill these positions on a permanent basis. The MOH will designate one staff from within its staff to take on the M&E functions.

Role of Partners (if applicable)

136. As under the MHSS project, an open coordination will be maintained with key health sector partners. WHO has reactivated the Harmonization for Health in Africa (HHA) coordination channel which was created as a mechanism to facilitate and coordinate the process of country-led development in all aspects of health systems strengthening. The Bank participates in the HHA meetings to share updates on project activities and learn of focus areas and activities of key partners. While there is no direct implementation of Bank-financed project activities by other donors, the Bank does coordinate activities, particularly with USAID and the EU to ensure there is no multiple coverage of geographic areas and that the same tools developed for national health system functions, such as the planning and budgeting tool and the health information system, are rolled out in a coordinated manner to the geographic areas covered by the different donors.

ANNEX 3: IMPLEMENTATION SUPPORT PLAN

COUNTRY : Angola
Angola Health System Performance Strengthening Project (HSPSP)

Strategy and Approach for Implementation Support

137. The MOH will have overall responsibility for project implementation. The National Department of Public Health (DNSP) will be responsible for the day-to-day implementation of the project. A specific Project Coordination Unit (PIU) within the MOH will be established that will be physically housed in the DNSP offices. The PIU will consist of MOH staff who will occupy the following roles: A Project Director who reports to the National Director of Public Health, a Project Coordinator, a PBF Project Coordinator, an M&E Specialist, a project Financial Management (FM) Specialist, and a Procurement Specialist, who all report to the Project Director. In addition, to further support the fiduciary capacity, the PIU will include two finance staff and a Procurement Assistant. 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 instead of relying primarily on international consultants.

Implementation Support Plan and Resource Requirements

138. 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 six-month to one-year period who will train the MOH staff who will take on these positions within the PIU. The project FM Specialist to be recruited will train the two MOH finance staff to be deployed at the PIU, where one of them will be selected to take over the position of project FM Specialist 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.

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First twelve months	Fiduciary	FM, Accounting, Procurement	US$200,000	NA
12-48 months	RBF	RBF	US$100,000	NA
Other				

Skills Mix Required

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Operations	13	3	
Health Economist	10	3	
Health Specialist	12	3	
RBF Specialist		2	
Procurement		3	
FM		2	

Partners

Name	Institution/Country	Role
NA	NA	NA

ANNEX 4: Results-Based Financing Design

139. To improve efficiency, access, and utilization of quality health services, the Government has agreed to pilot a Results Based Financing (RBF) approach. The Government recognizes the need to address the challenges related to the allocative and technical efficiency of its public health expenditure. One of the recommendations of the Health Public Expenditure Reviews carried out by the World Bank in partnership with the Ministry of Finance and with inputs from the Ministry of Health in 2017 was to explore the potential of a PBF approach to address the efficiency and effectiveness issues at the primary health care level. With the participation of the World Bank, the World Health Organization, and USAID, the Government of Angola established a working group to begin to develop a health financing strategy. This strategy aims at ensuring efficiency of the health system and increased utilization of health services, with a focus on Reproductive, Maternal, Neonatal and Child Health and includes exploring the role of RBF approaches. With the assistance of its partners, including the World Bank, the government is preparing a National Health Care Financing Strategy.

140. Angola's RBF approach will focus on piloting the supply side Performance-Based Financing (PBF) scheme. RBF is an instrument that links financing to pre-determined results, with payment made only upon verification that the agreed-upon results have actually been delivered. RBF can help improve both supply (e.g. Performance Based Financing – PBF) and demand side performance (e.g. Conditional Cash Transfers – CCTs) of health systems striving for Universal Health Coverage (UHC). RBF program payments are made based on the quantity and quality of health services delivered after verification (WB, 2013, Africa Health Forum). In the case of Angola, the focus will be on PBF, which is the supply-side RBF approach. PBF pays for outputs or results and this is different from classical programs which focus on procuring inputs. In the health sector, such outputs or results include quality services produced by health facilities/providers and certain actions by the health administration. Income from PBF is used by health facilities and the health administration to procure necessary inputs and to pay performance bonuses.

141. International experience indicates that RBF approaches can be successful in rapidly increasing the use of cost-effective health interventions in a country like Angola. Studies of RBF in Cambodia and Burundi and randomized controlled studies in Rwanda and Zimbabwe have demonstrated its effectiveness. There are promising results from several countries in Sub-Saharan Africa that suggest that RBF may be a useful approach to address the types of challenges present in Angola (inequity/social exclusions, low technical and allocative efficiency). The Rwandan experience has attracted considerable interest and has yielded results in terms of increasing the proportion of the right skills mix in public sector facilities, increasing financing to the district level, and improving the coverage of quality maternal and child health services.

142. The PBF scheme will be a key instrument in ensuring the country's Universal Health Coverage (UHC) mandate is indeed being implemented across Angola. Angola, by law, makes health care available to its population for free. While the law and principle does exist, in practice, factors such as arbitrary allocations to health at the municipal level and the inadequacy of inputs for providing minimal quality health services impedes UHC being a reality. RBF approaches can have a positive impact on the UHC agenda, in general, through mainly three areas (Fritsche G.B. et al., 2014): defining the basic and complementary health package and delivering these packages; expanding coverage of health services for the general population and especially for the poorest; and improved utilization of good-quality health services.

Coordination with Social Protection Efforts

143. The PBF scheme will benefit from ongoing and existing efforts led by the social protection team which

include the Government of Angola having developed a Presidential Decree to create a Social Registry. Under a Rapid Social Response (RSR) Grant, the World Bank is working with the Government of Angola in establishing two key system elements: a Social Registry of safety net beneficiaries, and a payment system designed to reach even remote safety net beneficiaries. To date, the Government has developed a Presidential Decree to create a Social Registry (Cadastro Único). It will be housed in the Ministry of Social Assistance and should eventually include the household data from all main safety net programs. The RSR would support the development of a common targeting template/questionnaire. It would also support the Ministry of Family, in collaboration with the Ministry of Social Assistance, in using and applying the agreed questionnaire in the context of the Combate a Pobreza programs. Finally, the RSR would work with the mentioned ministries to collaboration with the Ministry of Health to use the data to be generated from this targeting process to help identify the beneficiaries at the municipal level receiving assistance from health and nutrition services, thus establishing collaboration between the services and the cash transfer programs of the Ministry of Family. This mechanism will serve as a key input in the development of the Results Based Financing (RBF) scheme to be piloted under the project.

Contracting and Flow of Funds

144. 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. As part of the contracting scheme, contract management skills will need to be developed and strengthened in both ministries. The MOH will work with the MoF to: (i) develop and manage the contracts that are to be entered into by the provinces/municipalities with the MOH 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.

145. The PBF pilot aims at : (i) demonstrating that the contracting mechanism creates the enabling environment for positive behavior change for health workers which leads to increased productivity in quantity and quality of services); and (ii) identifying and supporting the institutional changes needed for the contracting mechanism to be developed within the framework of the national budget in order to reduce inefficiencies in spending and increase financial accountability of actors at different levels of the health care system. 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.

Target Municipalities

146. The Government will define the municipalities where the PBF approach will be piloted based on a set of criteria. To begin with, the target provinces and municipalities supported under the project already represent among the most challenged areas in terms of health outcomes. From a total set of 162 municipalities already targeted under the project, the PBF scheme will be piloted in four municipalities. These four municipalities will be selected based on indicators such as poverty, deliveries outside facilities, use of and access to health

facilities, rural population, and health spending per capita.

147. The proposed sub-component aims to improve utilization of quality Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMHCAH) services in selected municipalities which have some of the highest poverty level and highest non-facility birth rates in Angola. The HSPSP focuses on strengthening municipal health services, as such, the PBF scheme will be focused at the municipal level. The interventions are targeting community health workers, health facilities (health posts, health centers and municipal hospitals), local Non-Governmental Organizations (NGOs) and Civil Society Organizations (CSOs), and relevant institutions, mainly Ministry of Health but also the Ministry of Administrative Territory (MAT), and the Ministry of Social Affairs in order to enhance the supply side of the health system, building on existing efforts.

Implementation

148. The PBF approach will be implemented in a phased manner.
- The first year (2018) 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.
- The second year (2019) will see the start of PBF activities.

Subsidies and Payments

149. PBF subsidies will be made for the delivery of select health services in public facilities in providing payments and small investment grants to eligible RMNCAH service providers (posts, centers and hospitals), in accordance with the qualitative and quantitative indicators specified in the PBF Manual. These services may include nutrition services, prevention services, maternal, neonatal, adolescent, infant and child health services, along with malaria, HIV/AIDS, tuberculosis, and family planning. As the program evolves, the package may be adjusted. Services and performance indicators will be clearly defined by the PBF manual that differentiates the list of Minimum Package of Activities (MPA) for health posts/centers from the list of Complementary Package of Activities (CPA), for municipal hospitals.

150. PBF payments will be linked to pre-defined qualitative and quantitative indicators. The quality assessment will be undertaken (i) at the community level to evaluate the quality perceived by the population as well as (ii) at facilities level (technical verification). PBF payments will then be used to (i) strengthen motivation of health workers through bonuses based on the performance of the health workers and (ii) improve the utilization and quality of care based on the development of a “Health Facility PBF action plan” where key investments will be identified. Such activities could include conducting outreach activities, purchasing light equipment, commodities, drugs, etc. The share of health workers’ bonuses in the PBF payment will not exceed 40 percent, with the remaining funds allocated to pre-agreed activities in the facility business plans.

151. Investment grants will be provided to public health facilities that meet certain criteria (to be defined in the PBF manual). These payments, in form of lump sums will finance light equipment in order to upgrade concerned facilities before starting the PBF process (and once the MOH approves the “Health Facility PBF action plan”, prepared by each health facility).

152. Project proceeds will finance payments to facilities and providers for services rendered. These payments will be based upon the criteria set out in the PBF manual and as validated by the verification and counter-

verification activities. Payment to CHWs will be made through the health facility. Once the CHWs are evaluated, each CHW will be paid through the health facility to which they are linked, to reduce transaction costs. Each quarter, the performance of CHWs will be consolidated at concerned health posts/centers. Payment of the performance will be done in one operation directly to the facility. In turn, this health facility will transfer the funds to CHW who will be paid according to their individual performance.

Community Engagement

153. The PBF scheme will support actions to strengthen the engagement of Community Health Workers. Project proceeds will support the MOH to complete its community health strategy which will be articulated in the "Health Facility PBF action plan". The strategy will include community-focused actions to engage the Community Health Workers (CHWs) which are known as the ADECOS in Angola. Examples of possible activities that could be incentivized under the PBF scheme include: (i) health promotion and prevention, (ii) simple and basic curative services, (iii) referral services to appropriate health centers, and (iv) community-based distribution of some inputs (e.g. nutritional ingredients, condoms, and bed nets). The performance of CHWs will be assessed through a double evaluation grid to measure both the quantity and quality of services provided.

154. The PBF scheme will also support actions to strengthen outreach by the health facilities to the community. As part of the community health strategy, the PBF scheme will contract an NGO/CSO to conduct a beneficiary survey every six months at the target health facilities of the PBF scheme. Under the PBF scheme, a percentage of the performance payment to the health facility will be determined by the qualitative score based on the results from the beneficiary score-cards implemented twice a year. Surveys undertaken by local NGOs on perceived quality of health care by the users / population will be used to construct an indicator pertaining to the satisfaction of the beneficiaries. Each semester, this indicator will be automatically calculated through the PBF database. It will be a good indicator to regularly monitor the voice of the community under the HSPSP project.

Verification and Counter-Verification

155. Rationale and types of verification. Since payments are linked to the volume and quality of pre-defined services, there are incentives to inflate the reporting. Verification, done by the MOH, and counter-verification, done by third parties, will minimize the risk of fraud and errors in reporting. Furthermore, sanctions to be included in the contract with health facilities will mitigate the risk of fraud and over reporting. There will be two aspects to the verification: the "ex-ante" verification will be done, every quarter, before the payment is made and counter verification or "ex-post" verification will be done every semester, after payment is made. If phantom patients or over reporting is identified because of the counter verification, health facilities will be deducted the PBF amount from their subsequent payment and will receive a first warning to mitigate the risks of fraud.

156. Verification agents will include (i) the MOH Gabinete de Estudos, Planeamento, e Estadistica (GEPE) which has the overall planning and coordination function in the MOH, (ii) the Provincial Health Services Departments who have responsibility over the health services across a set of municipalities; (iii) NGOs/CSOs (community-focused) will manage community verification (accuracy of health services provided) and the quality of health services perceived by users; (iv) Health Centers/Posts will be in charge of the verification related to CHWs; and (v) counter verification will be undertaken by contracted out independent entities which can include the Escola Nacional de Saúde Pública or the Instituto National de Estatística. Surveys

undertaken by local NGOs on perceived quality of health care by the users / population will be used to construct an indicator pertaining to the satisfaction of the beneficiaries. Each quarter, this indicator will be automatically calculated through the PBF database. It will be a good indicator to monitor regularly the voice of the community under the HSPSP project.

157. Project proceeds will finance the verification and counter-verification activities and will pay performance bonuses to PBF implementing bodies. These entities play a key role in the PBF operations and success of the program. They will receive bonuses for performance according to rules defined by the PBF Manual.