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Report No: PAD5465

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT APPRAISAL DOCUMENT
ON A
PROPOSED LOAN

IN THE AMOUNT OF US$200 MILLION

TO THE

REPUBLIC OF ANGOLA

FOR A

HUMAN RESOURCES CAPACITY FOR UNIVERSAL HEALTH COVERAGE IN ANGOLA PROJECT

May 31, 2023

Health, Nutrition, and Population Global Practice
Eastern and Southern Africa Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective April 30, 2023)

Currency Unit =	Angolan Kwanza (AOA)
US$1 =	AOA 511.50

FISCAL YEAR

January 1 - December 31

Regional Vice President:	Victoria Kwakwa
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ABBREVIATIONS AND ACRONYMS

AM	Accountability Mechanism
CERC	Contingent Emergency Response Component
COVID-19	Coronavirus Disease 2019
CPS	Country Partnership Strategy
DA	Designated Account
DFIL	Disbursement and Financial Information Letter
ESF	Environmental and Social Framework
FM	Financial Management
GBV	Gender-Based Violence
GCRF	Global Crisis Response Framework
GDP	Gross Domestic Product
GGE	General Government Expenditure
GHG	Greenhouse Gas
GHE	Government Health Expenditures
GoA	Government of Angola
GRM	Grievance Redress Mechanism
GRS	Grievance Redress Service
HCI	Human Capital Index
HDI	Human Development Index
HRH	Human Resources for Health
HRIMS	Human Resource Information Management System
HSPSP	Health System Performance Strengthening Project
IES	Institute of Specialization in Health
ICT	Information and Communication Technology
IFR	Interim Financial Report
INAREES	National Institute for Evaluation and Accreditation of Higher Education (*Instituto Nacional de Avaliação e Reconhecimento de Estudos do Ensino Superior*)
IT	Information Technology
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
MoH	Ministry of Health
NAPA	National Adaptation Programme of Action
NHS	National Health System
NSPH	National School of Public Health
PBC	Performance-Based Condition
PDO	Project Development Objective
PIM	Project Implementation Manual
PIU	Project Implementation Unit
PNDS	National Health Development Plan (*Plano Nacional de Desenvolvimento Sanitário*)
PPSD	Project Procurement Strategy for Development
REDISSE	Regional Disease Surveillance Systems Enhancement
SDI-TM	Service Delivery Indicator Tracking Module
SEA/SH	Sexual Exploitation and Abuse and Sexual Harassment

SORT	Systematic Operations Risk-rating Tool
SOUR	Statement of User Requirements
SPRP	Strategic Preparedness and Response Project
STEP	Systematic Tracking of Exchanges in Procurement
TEST	Tertiary Education, Science, and Technology Project
TOR	Terms of Reference
TTL	Task Team Leader
UAN	*University Agostinho Neto (Universidade Agostinho Neto)*
UCC	Central Coordinating Unit (*Unidade Central de Coordenação*)
UNDP	United Nations Development Programme
WBG	World Bank Group
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Angola	Human Resources capacity for Universal Health Coverage in Angola	
Project ID	Financing Instrument	Environmental and Social Risk Classification
P180631	Investment Project Financing	Moderate

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[√] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[ ] Performance-Based Conditions (PBCs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	[ ] Hands-on Enhanced Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date
22-Jun-2023	29-Dec-2028

Bank/IFC Collaboration
No

Proposed Development Objective(s)

The Project Development Objectives is to Improve the capacity and availability of Human Resources for Health in Angola.

Components

Component Name	Cost (US$, millions)

HRH Governance, Policy, Curricula, and Information Systems	15.00
Training and capacity building of HRH	175.00
Project Management and Monitoring and Evaluation	10.00
Contingent Emergency Response Component (CERC)	0.00

Organizations

Borrower:	Republic of Angola
Implementing Agency:	Republic of Angola - Ministry of Health (MOH)

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	200.00
Total Financing	200.00
of which IBRD/IDA	200.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	200.00

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2023	2024	2025	2026	2027	2028	2029
Annual	0.55	25.00	50.00	50.00	45.00	29.45	0.00
Cumulative	0.55	25.55	75.55	125.55	170.55	200.00	200.00

INSTITUTIONAL DATA

Practice Area (Lead)	Contributing Practice Areas
Health, Nutrition & Population	

Climate Change and Disaster Screening

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

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
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	Moderate
9. Other	Substantial
10. Overall	Moderate

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

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Relevant
Cultural Heritage	Not Currently Relevant
Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Sections and Description
Schedule 2 Section I B (PIU)
1. The Borrower through MoH shall maintain, throughout the Project implementation period, a project implementation unit ("PIU"), with composition, mandate, and resources satisfactory to the Bank as detailed in the Project Implementation Manual. To this end, the PIU shall:
(a) (i) maintain key staff, including; a technical manager, a procurement assistant/specialist, and a financial management assistant/specialist; (ii) no later than one (1) month after the Effective Date appoint or hire, and thereafter maintain one social safeguard technical assistant; and (iii) no later than three (3) months after the Effective Date appoint or hire, and thereafter maintain, an accountant, a monitoring and evaluation specialist, and two technical health education and ethics specialists, all with qualifications, experience, and terms of reference acceptable to the Bank;

Sections and Description
Schedule 2 Section IV (Other Undertakings)

The Borrower through MoH, shall: (a) no later than (3) months after the Effective Date acquire and thereafter maintain a computerized financial management and accounting software; and (b) no later than (6) months after the Effective Date recruit an external auditor; all in form and substance satisfactory to the Bank.

Conditions

Type	Financing source	Description
Effectiveness	IBRD/IDA	The Borrower, through the MoH has adopted the Project Implementation Manual in form and substance satisfactory to the Bank.
Effectiveness	IBRD/IDA	The Borrower, through the MoH has established the PIU under terms and conditions acceptable to the Bank (including key staff as per Section I.B1(a)(i) of Schedule 2 to this Agreement).
Disbursement	IBRD/IDA	Under Category (2), until and unless the Borrower has presented: (i) the Training Manual; and (ii) the first two Training Agreements; all in form and substance satisfactory to the Bank;
Disbursement	IBRD/IDA	Under Category (3), until and unless: (i) the Borrower has determined that an Eligible Crisis or Emergency has occurred, and has furnished to the Bank a request to withdraw Loan amounts under Category (3); (ii) the Bank has agreed with such determination, accepted said request and notified the Borrower thereof; and (iii) the Borrower has adopted the CERC Manual and Emergency Action Plan, in form and substance acceptable to the Bank.

I. STRATEGIC CONTEXT

A. Country Context

1. **Angola is a lower-middle-income country with 34 million people and an economic model highly dependent on oil.** As one of Sub-Saharan Africa's (SSA) largest oil producers—oil accounting for over 90 percent of exports, 60 percent of fiscal revenues, and 33 percent of gross domestic product (GDP) (2021)—the economy is non-diversified, highly vulnerable to external shocks, and generates few jobs. This non-inclusive economic model, coupled with weak governance, has constrained the benefits from Angola's oil wealth, as one-third of the country's population lives in extreme poverty (32.7 percent in 2022, at US$2.15 per day, 2017 purchasing power parity)—high for a middle-income country—and it had a Gini index of 51.3 in 2018.[1] Historic underinvestment in social sectors has resulted in weak human development indicators, with a Human Capital Index (HCI) score of 0.36 in 2020, which is below economic comparators and the SSA average of 0.4. Girls fare worse than boys in most of the HCI's health and education measures.[2] Angola ranks 149 out of 182 countries in the Human Development Index (HDI) of the United Nations Development Programme (UNDP).

2. **After exiting a five-year recession in 2021, Angola's economic recovery remained strong in 2022, with growth projected on average around 2.4 percent for the 2024 – 2025 period.** During the period of high oil prices, from 2005 to 2014, Angola recorded rapid economic growth. When oil prices declined in 2015, Angola fell into a recession, with a cumulative decline of 3.8 percent in real GDP from 2015 to 2019. The sharp drop in oil prices in early 2020 brought on by coronavirus disease 2019 (COVID-19), coupled with measures put in place to contain the pandemic, further exacerbated the economic downturn, and GDP declined by 5.6 percent in 2020. With higher oil prices and the lifting of mobility restrictions in 2021, growth stood at 0.8 percent. Through recent upward pressures on global oil prices, Angola is benefiting from significant windfall gains. Growth is projected on average around 2.4 percent 2024 – 2025, driven mainly by the non-oil sector. The Government is taking advantage of this period of high oil prices to further advance important reforms initiated over the past years. The floating of the exchange rate since 2018 has served as a shock absorber and will support economic diversification but, in the short term, has led to higher inflation. Rapid currency depreciation also contributed to a steep rise in the debt-to-GDP ratio, reaching 131 percent in 2020, but as oil prices and the currency recovered and fiscal prudence is maintained, this ratio is estimated to have declined to 65 percent in 2022.

3. **The COVID-19 pandemic, severe and persistent climate change-induced droughts and flooding, and multiple infectious disease epidemics have hampered Angola's development efforts.** The frequency and the severity of the droughts in the southern provinces of the country puts 40 percent of the population at risk of acute food insecurity.[3] The country is flood prone, with floods accounting for 55 percent of the natural disasters experienced in the country between 1980 and 2020.[4] These negatively affect livelihoods, settlements, and incomes of households while increasing the spread of vector and

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[1] World Bank data for Gini index: https://data.worldbank.org/indicator/SI.POV.GINI?locations=AO. This is up from 42.7 in 2008.
[2] World Bank. Human Capital Project - October 2020.
[3] Integrated Food Security Phase Classification, Angola. Angola: Acute Food Insecurity Situation and Acute Malnutrition Situation April 2021 - March 2022
[4] Climate Change Knowledge Portal, Angola.

water borne diseases.[5] The number of people affected by these natural disasters are expected to increase in the coming years and may worsen food insecurity, malnutrition, and the ability of the health sector to respond to health care needs of the population. With lower incomes, health care may become unaffordable for most of the population. Additionally, the COVID-19 global crisis, which resulted in significant morbidity and mortality, also affected the country's economic and social development.[6]

4. **Angola's population is expected to more than double, to reach 68 million by 2050, rising at an annual growth rate of 3.3 percent.** Life expectancy is expected to increase from 61 years in 2023 to 68 years in 2050 (see figures 1 and 2).[7] The Angolan population is young, 45 percent being under 15 years of age, and 52 percent are women. The urban population represents about 65 percent of the total population, with about one-quarter of the population living in the capital, Luanda.

Figure 1. Angola Population Projection

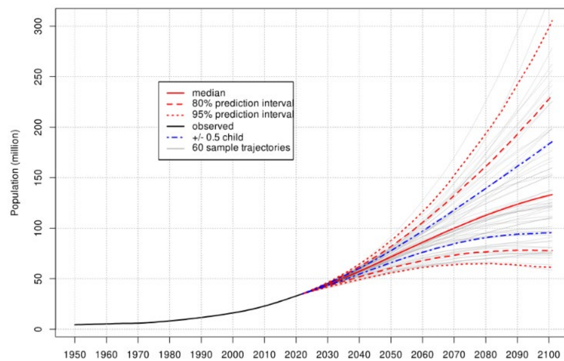
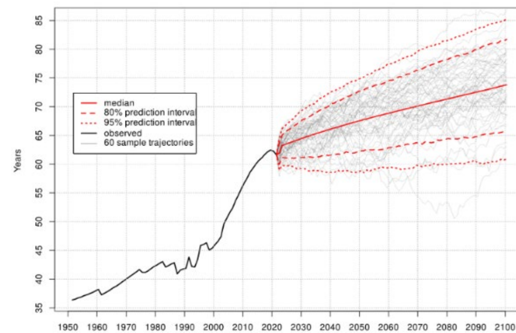


Figure 2. Angola Life Expectancy Projection



Source: United Nations, World Population Prospects 2022.

5. **Weak governance and a centralized administrative structure hamper service delivery.** Though a decentralization policy was introduced in the early 2000s, the administrative structure in Angola remains highly centralized and shows weaknesses in human resources and public finance management. Provincial and local levels have limited administrative and human resource capacity, resulting in regional inequalities and a deep urban/rural divide. Weaknesses in accountability and coordination mechanisms between the central and local authorities are reflected in the country's poor rankings in several internationally recognized indexes that track governance performance, including Transparency International's 2020 Corruption Perceptions Index where Angola ranked 142 out of 180 countries. There are ongoing efforts to use information technology (IT) to strengthen public sector processes and accountability. The Kwenda Program, launched in 2020, for example, uses technology to support social registry and payment mechanisms. A national civil registration and unique identification system *(Bilhete de Identidade)* has also been rolled out to replace taxpayer identification and voter ID number. Uptake and use to enable this

[5] Perez-Saez, Javier, Justin Lessler, Elizabeth C Lee, Francisco J Luquero, Espoir Bwenge Malembaka, Flavio Finger, José Paulo Langa, Sebastian Yennan, Benjamin Zaitchik, and Andrew S Azman. 2022. "The Seasonality of Cholera in Sub-Saharan Africa: A Statistical Modelling Study." *The Lancet Global Health* 10 (6): e831–e839. ISSN 2214-109X. https://doi.org/10.1016/S2214-109X(22)00007-9.
[6] UNCTAD (United Nations Conference on Trade and Development). Economic and Social Impact and Effect of COVID-19 in Angola 2021. https://unctad.org/webflyer/economic-and-social-impact-and-effect-covid-19-angola-2021.
[7] World Population Prospects, United Nations 2022.

transformation are, in general, low among citizens and businesses. The digital architecture is also fragmented, with limited interoperability between databases.

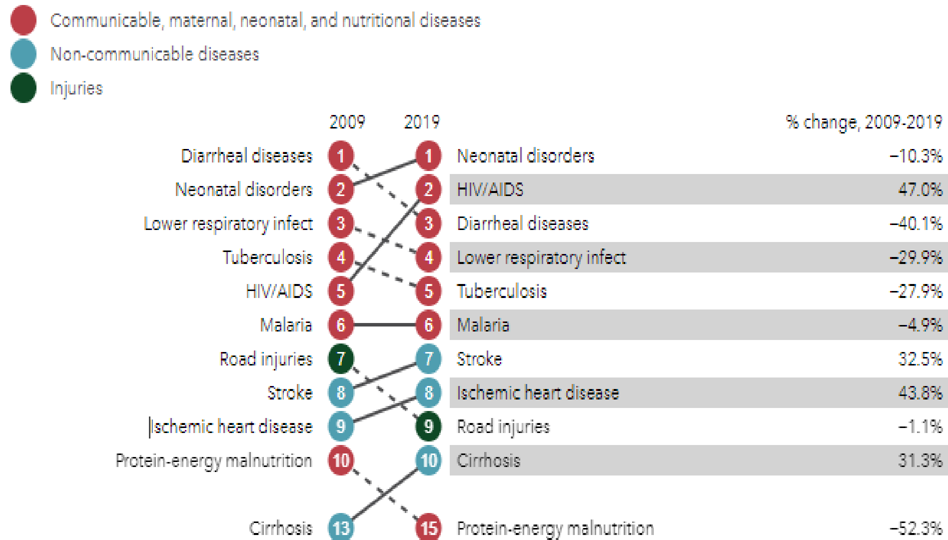
6. **Angola has adopted legislation to end gender discrimination across all domains of daily life, such as employment, land ownership, health, and basic rights.** In 2018, the Government established the Ministry of Social Protection, Family, and Promotion of Women to focus on gender equality and equity. This, coupled with other efforts, led to Angola scoring 79.4 percent on the Women, Business, and the Law index—higher than the global (76.5) and regional averages (71.4).[8] In 2022, close to 30 percent of the seats in Angola's national parliament were held by women. However, many challenges remain. About one-third of Angolan women have reported gender-based violence (GBV).[9] The country has some of the worst outcomes on female-related health indicators globally as described in the next section, with adolescent girls at particular risk. Teenage girls (15–19 years old) have the highest adolescent birth rates recorded globally, at 162 births per 1,000 girls.

B. Sectoral and Institutional Context

7. **Recent progress in human development indicators have been recorded, though significant challenges lie ahead.** Between 2000 and 2019, life expectancy at birth increased from 47 years to 61 years, infant mortality (43.8 per 1,000 live births) dropped by almost two-thirds, and maternal mortality (241 per 100,000 live births) decreased by 70 percent.[10] However, a high fertility rate, at 5.4 births per woman, and an adolescent fertility rate of 143 per 1,000 births, coupled with a growing population, put significant pressure on the health system. Malaria continues to be widespread, with more than 6.2 million cases, and is the number one cause of mortality with more than 10,400 deaths recorded in 2020. The HIV/AIDS prevalence rate is around 2 percent, but with low levels of antiretroviral treatment coverage.[11] The tuberculosis incidence rate is 350 per 100,000 population.[12] There is an observable rising rate of noncommunicable diseases, with cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases accounting for 27 percent of deaths in 2019 (see figure 3).[13] As of March 2, 2023, Angola had recorded 105,095 COVID-19 cases, including 1,930 deaths, with an overall case fatality of 1.8 percent. As of March 1, 2023, Angola had administered more than 24.6 million COVID-19 vaccines, which translates into a coverage rate of 81 percent of the eligible population (over 12 years) having received one dose, and 45 percent being fully vaccinated[14].

[8] USAID Angola Profile. *https://idea.usaid.gov/cd/angola/gender*.
[9] Afrobarometer, 2023. In Angola, gender-based violence is seen as the top challenge to women's rights
[10] Ministry of Health (MoH) Annual Epidemiological Report.
[11] Demographic and Health Survey 2015.
[12] World Health Organization (WHO) Angola TB profile.
[13] Global burden of 369 diseases and injuries in 204 countries and territories, 1990–2019.
[14] Angola MoH. ReDIV system. Digital Angola Platform for COVID19 vaccination real-time registration.

Figure 3. Angola Mortality Causes 2019



Source: Institute for Health Metrics and Evaluation; Global Burden of Diseases 2019.

8. **Health services provided by the National Health System (NHS) are free and delivered through a three-level pyramidal system that has seen recent improvements.** Since 2020, the MoH has made significant investments in building tertiary-level care facilities with state-of-the-art equipment across the country. This has improved the availability of tertiary care for the population. Public hospitals and clinics, however, remain underfunded and understaffed. Private health insurance and access to private health care providers are mainly concentrated in Luanda and limited to those who have steady employment. There are around 3,338 functioning public health facilities within the NHS (MoH data, January 2023). Health posts and health centers represent 86 percent of these facilities and serve as the base for the population's primary health care access. There is, however, an inequitable distribution of health facilities across urban and rural areas. Furthermore, a weak referral and counter-referral system, low numbers, maldistribution and quality of human resources, and inadequate management of medicines and medical devices pose significant challenges in the provision of health care. This is a result of years of inefficient management, underinvestment, and regulation of the health sector in Angola, which the current administration is working to address.

9. **Per capita public spending in the health sector increased more than fourfold (in real terms) during the oil boom years of 2000–2013 but decreased as growth declined post-2014.** Between 2000 and 2015, total health spending and per capita expenditures on health were low compared with countries at the same or lower-income levels. The lower health expenditures were due to spending cuts in 2014, 2015, and 2017, by 16, 11, and 2 percent, respectively. In 2019, the Government spent 5.43 percent of general government expenditure (GGE) on health, which is below that of comparator countries (see figure 4). Moreover, almost half of government health expenditures (GHE) is for wages for the health workforce (see figure 5).

Figure 4. GHE as Share of GGE (2019/2020)

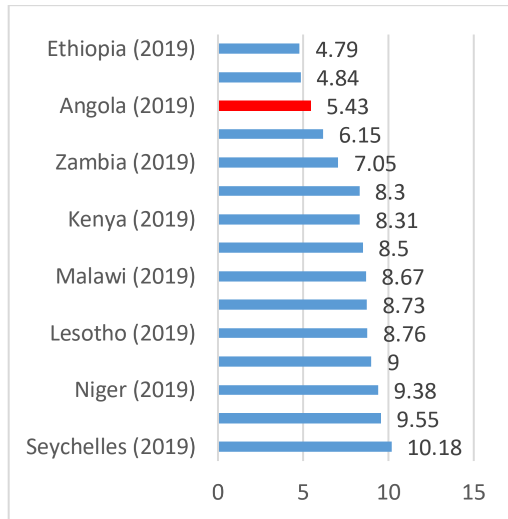
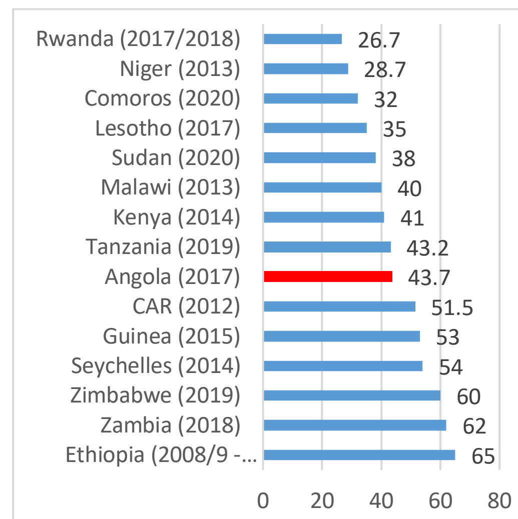


Figure 5. Wages as Share of GHE (2019/2020)



Source: World Bank Public Expenditure Reviews (2019/2020) – Health.

10. **Despite the increase in the supply of tertiary education in health sciences, the quality of undergraduate education is still suboptimal.** Tertiary, undergraduate education in Angola is under the mandate of the Ministry of Higher Education. Undergraduate training of medical doctors and nurses is currently offered in seven provinces throughout the country (out of a total of eighteen). About 1,200 doctors and 5,000 nurses and other undergraduate-level health professionals graduate annually. Furthermore, Angola has several institutions that offer higher education in the medical sciences including 18 health technical schools (one per province). The supply of such courses has expanded rapidly, without proper regulatory protocols in place to standardize the levels of quality, resulting in varying teaching methods and quality of instruction. The absence of a national, unified curriculum further hampers the prospects of ensuring minimum quality standards. Regulatory mechanisms between universities and hospitals are needed to improve the integration process of health professionals from academia into the health care service industry.

11. **Between 2018 and 2022, the health workforce increased significantly from 33,093 to 96,346, boosted by large-scale hiring of technical nurses (high school diploma) and other nonmedical professionals.** Over the last years, there have been efforts by the MoH to admit all graduating medical doctors into the civil service through a yearly public mass hiring process. Similarly, there have also been efforts to hire nurses and other cadres of health care professionals. While investments in human resources for health (HRH) have increased, the efforts have not resulted in an optimal supply of health care professionals, skills mix, and distribution of health care professionals. The density of doctors is estimated at around 2.2 per 10,000 people, that of nursing and midwifery personnel at 8.4 per 10,000 people, and that for other health care personnel at 13.6 per 10,000 people. While these statistics are comparable to the Sub-Saharan Africa data, they are significantly lower than global estimates or the ones for middle-income countries.[15] These estimates show significant inequities between provinces and between urban and rural areas. The increasing double burden of disease, rapid urbanization, population dynamics, and

[15] Measuring the availability of human resources for health and its relationship to universal health coverage for 204 countries and territories from 1990 to 2019: a systematic analysis for the Global Burden of Disease Study 2019. https://doi.org/10.1016/S0140-6736(22)00532-3.

higher health literacy levels will most likely lead to the need and demand for better qualified and specialized physicians, nurses, and other health care professionals in the future.

12. **Less than 900 out of the estimated 7,000 medical doctors and only about 10 percent of nurses have received post-graduate or specialized training.** About 30 percent of the specialists in the country are expatriates, with temporary assignments and no obligation to train local staff. This has negatively affected the state budget, sustainable human resource development, and capacity building of local staff. The Government of Angola (GoA) spends, on average, around US$76 million on expatriate human resources per year. In 2020, Angola started specialty training programs for doctors in five provinces. As of 2023, the program was further expanded with about 2,500 medical doctors currently attending specialty training in 17 provinces in the country. The key programs offered are family medicine, internal medicine, general surgery, gynecology and obstetrics, pediatrics, and trauma surgery. The MoH intends to admit 1,000–1,500 doctors and nurses per year into specialty training programs and graduate about a thousand annually from 2024. The Angolan Medical Council has defined the curricula for medical specialties and post-graduate training. These need to be further revised and updated to align with international best practices while reflecting the local context. For nurses and other health care professionals, there are severe shortcomings in policy and career progression legislation, which hinder their professional growth/development.

13. **Further, across the world, women's paid labor accounts for 70 percent of the health care workforce and is more likely to be frontline workers[16], Angola is no different.** Health systems rely on women's paid labor to function effectively. Yet, global evidence illustrates the discrimination women face as health care workers—as in other sectors of the economy—with less access to training, lower wages, fewer chances for promotion, sexual harassment on the job, and other disadvantages relative to their male colleagues.[17] HRH can also provide the much-needed wage employment for women. The scarcity of gender-disaggregated data for HRH in Angola hinders definitive conclusions but available data point to a higher percentage (60 percent) of women working at less specialized cadres, namely mid-level health care workers at the community level. However, when looking at the more specialized cadres such as doctors and nurses this percentage is lower for women than men (40 percent). Finally, though sex and gender are critical determinants of health and wellness, training curricula for health care providers typically ignore gender.[18] This gap is increasingly recognized as problematic and the WHO has included attention to sex and gender in early health curriculum training material.[19]

14. **Digital health is widely recognized as a potential tool to advance the Sustainable Development Goals and support health systems, as evidenced during the COVID-19 outbreak.** With the World Bank's technical and financial support through the Angola COVID-19 Strategic Preparedness and Response Project (SPRP)(P176630), Angola turned the COVID-19 challenge into a development opportunity, by embarking on a digital transformation. The rollout of the real-time COVID-19 vaccine platform (ReDIV), a digital platform for nominal preregistration for COVID-19 vaccines, issuing a unique identifier to each registered individual, and facilitating their monitoring in real time throughout the vaccination process, has been a huge achievement under the MoH leadership. The ability of the country to implement this system across all 18 provinces was impressive and indicative of a good scale-up process. Angola's Human

[16] WHO – Value, gender and equity in the global health workforce.
[17] Lancet. 2020. The Impact of Gender Discrimination on a Woman's Mental Health.
[18] Verdonk, P., Benschop, Y.W.M., de Haes, H.C.J.M. et al. From gender bias to gender awareness in medical education. Adv in Health Sci Educ 14, 135–152 (2009).
[19] WHO 2005. Integrating Poverty and Gender into Health Programmes.

Resources for Health Information Management System (HRIMS), however, is not currently digitalized and presents challenges for projecting need, efficient distribution, accountability, and performance management. Introducing HRIMS with the support of IT will significantly improve the ability of decision-makers to better forecast need, equitably distribute the workforce, and manage their performance and progress across the country. The GoA has also expressed the desire to introduce distance learning, computer-based instruction, and virtual simulation education, as these have shown to be efficient ways of engaging professionals and promoting maximum care and supervision. Additionally, the implementation of a telemedicine platform should enable better utilization of specialized services supporting primary care professionals, especially in more remote areas. Telemedicine involves the use of digital technologies to overcome distance barriers in the delivery of health services and has the potential to improve clinical management and extend the coverage of services. The demonstrated benefits of provider-to-provider telemedicine services include more timely care and expanding access to underserved communities.

15. **The Minister of Health, by a decree Nº10/GAB.MIN/MS/2023, nominated a Task Force, headed by the Secretary of State for Public Health, to oversee a program of post-graduate training for health professionals.** The Task Force has representation from the Directorate of Human Resources for Health, Institute of Specialization in Health (IES),[20] Directorate for Hospitals, the Legal Department, and members of the key Faculties of Medicine and tertiary-level hospitals. The mandate of the Task Force is to design, develop, implement, and monitor the implementation of the National HRH Strategic Development Plan for Angola. The plan will focus on (a) strengthening the HRH planning, forecasting, and management of HRH based on needs and the decentralization process; (b) improving availability, accessibility, acceptability, and quality of human resources at all levels to adequately respond to current and future health sector needs; (c) establishing effective mechanisms for equitable deployment and retention of health workers; and (d) providing guidance on the required improvements, both in terms of the infrastructure and equipment required to ensure improved working conditions, especially in rural contexts. To reduce the heavy toll on the State Budget, the MoH has set the ambitious target of eliminating expatriate health professionals by 2027. This will require significant and focused investments in expanding the capacity for training and production of post-graduates in country.

16. **A Presidential Decree, Decree Law 67/23 of March 7, 2023, provides strong incentives for the decentralization of civil servants, which will be paramount for the equitable distribution of qualified health care workers in Angola.** This decree, which includes health care workers, will bring significant monetary incentives for the deployment of professionals to rural and impoverished areas and is a clear signal from the GoA on the priority placed on improving the equity of skilled professionals across the country. Decentralized staff will receive a 50 percent salary increase as a relocation allowance, 30 percent salary increase for monthly isolation/decentralization, 30 percent salary increase for housing, and priority transfers within the public sector for the accompanying spouse.

C. Relevance to Higher Level Objectives

17. **The proposed project aims to strengthen the availability and management of HRH and the quality of health care services provided, in support of the World Bank Group (WBG) Country Partnership Strategy (CPS) for Angola.** By investing in HRH at the national, provincial, and municipal levels, the

[20] The Institute of Specialization in Health was established by National Decree on June 9, 2022, with the mandate to promote, lead, regulate, accredit, certify, and perform supervision of post-graduate training in health.

proposed project will take Angola one step closer to its aspirations of achieving universal health coverage, which is key to achieving the WBG's twin goals of ending extreme poverty and increasing equity and shared prosperity. The project is also aligned with the priorities for the Eastern and Southern Africa region, namely the focus on building human capital and promoting gender equality. The project is aligned with the FY14–FY16 WBG CPS for Angola (Report No. 76225-AO), which was extended to FY20 through a 2018 Performance Learning Review (Report No. 100984-AO). It is also aligned with preliminary priority directions for WBG engagement over the coming CPF period, which includes support to increase access to and quality of services—with a particular focus on women and girls. A Systematic Country Diagnostic for Angola was finalized in December 2018 and identifies human capital strengthening as a priority for eliminating extreme poverty and boosting shared prosperity by: (a) improving education services; (b) improving health and nutrition services; and (c) expanding water and sanitation infrastructure and services.

18. **To support the GoA's focus on human capital in its National Development Plan (2023–2027), the World Bank is assembling a portfolio of interconnected, complementary operations.** This project is at the heart of this initiative, as it supports the country's recovery from the pandemic and elevates the country's investments in human capital for health to strengthen health systems delivery. This project builds on the Tertiary Education, Science, and Technology Project (TEST, P179154), which will upgrade the quality of undergraduate teaching, with a strong focus on the STEM[21] areas that serve as premedical training. The two operations have been designed in tandem such that the post-graduate training under this project builds on substantial upgrades in undergraduate training under TEST. Similarly, the quality assurance mechanisms being rolled out under TEST will prioritize the inspections and regulation of the Faculties of Medicine. Second, the Angola Digital Acceleration Project (P180593) that is forthcoming also offers important synergies with this project, specifically as it expands equitable access and use of broadband internet to improve digitally enabled public service delivery. This will benefit the post-graduate training focus and IT and innovation components of this project.

19. **The project incorporates key aspects of Angola's 2012–2025 National Health Development Plan (*Plano Nacional de Desenvolvimento Sanitário*, PNDS) and the forthcoming Health Sector Development Plan for 2023–2027.** The 2012–2025 PNDS aims to reduce malaria morbidity in the general population, maintain Angola's HIV/AIDS prevalence at 2 percent, triple the number of doctors per 10,000 citizens (from one to three), improve birth attendance by qualified staff (from 49 percent to 70 percent), and exponentially increase family planning services (from 6 percent to 45 percent). The plan will also address health financing and the efficient management of HRH. The MoH Advisory Board meeting held in December 2022 proposed the following thematic areas to be included in the 2023–2027 Health Sector Development Plan: (a) addressing of health financing challenges; (b) municipalization of primary health care to ensure their capacity to respond to the needs of the population and demographic challenges; (c) development of HRH to meet the needs of the population; and (d) improving of communications with the population, users, and institutions. The plan has a clear focus on building human capital, with provisions to strengthen the collaboration between the Ministry of Higher Education and MoH by prioritizing the health sector in accessing up to 1,000 international and 50,000 in-country scholarships for undergraduate students in health science fields. Further, this plan contains strategies for reducing the unequal distribution of health sector staff, addressing the needs of underserved municipalities, retaining staff, reformulating specific career creation and implementing performance evaluation systems, and

[21] STEM = Science, technology, engineering, and mathematics.

developing specialty programs with a focus on post-graduate and continuing education for health care professionals.

20. **The project is aligned with Pillar 4 of the Global Crisis Response Framework (GCRF) 'Strengthening Policies, Institutions and Investments for Rebuilding Better'.** While progress toward recovery remains highly uneven across countries, support for rebuilding better is taking root by maintaining a line of sight to long-term development goals. Support for modernization and capacity building of the public sector remains key for the design and implementation of policies and programs required to address higher poverty and lower growth prospects in most developing countries. Going forward, the need to support policy and institutional reforms will remain pressing, as will the need for budget financing for essential services. The proposed project and its three components are fully aligned with Pillar 4 of the GCRF*,* by investing in HRH reforms, institutional strengthening, and health-related human capital. The project will support the country to rebuild better after COVID-19 and raise the standards of care offered to the population through investments in the post-graduate qualifications of health care professionals.

II. PROJECT DESCRIPTION

A. Project Development Objective

21. **The Project Development Objective (PDO) is to improve the capacity and availability of Human Resources for Health in Angola.** The aim is to increase the number, quality, equity, and retention of post-graduates and specialty health care professionals for improved and more efficient health service delivery. The project will support the development and implementation of (a) a robust, comprehensive, and sustainable HRH implementation plan; (b) normative standards and policies for curriculum development, regulation, and staff progression; (c) a network of post-graduate training centers at national, provincial, and municipal levels; (d) post-graduate and continuous professional training for all cadres of health care professionals; (e) an HRH information system and support for the analysis and forecasting, production, distribution, management, monitoring, evaluation, and impact assessment of the HRH and service delivery; and (f) provider-to-provider telemedicine services to support health professionals and improve coordination and continuity among the different levels of care.

PDO Level Indicators

22. The proposed outcome indicators to measure achievement of the PDO are as follows:

(a) Increase in the number of health care workers with certified post-graduate level training from accredited facilities

(b) Improved density of doctors and nurses with post-graduate/specialized training

(c) Percentage of health professionals absorbed in public healthcare facilities after completing post-graduate training with project support

B. Project Components

Component 1: HRH Governance, Policy, Curricula, and Information Systems (US$15 million)

23. **Subcomponent 1.1: HRH Governance Systems and Policies (US$6 million).** There is the need to use evidence to develop policy and plans to guide human resource development. This subcomponent will finance the development of a series of reports that generate data on: (a) HRH with a narrative on the distribution and factors affecting the efficient production, management, and performance of health workers; (b) gaps in staff by specialty and skills mix based on different scenarios; and (c) gender disaggregation in the HRH in Angola and barriers to women accessing post-graduate specialized training in the country. The project will also support the development of a 10-year HRH Strategy and Action Plan (which will include an Action Plan on Gender to ensure that the findings from gender access assessments inform strategies to resolve identified barriers); define and develop relevant policies and standards to fill the gaps on staffing particularly in poor and climate vulnerable areas; policies to incentivize health workers to have exclusive contracts with the health sector; policies to regulate the private sector; policies on health care professionals' careers (including for community health care workers), progression, and remuneration. This subcomponent will support the client in developing policy measures to promote high absorption rates of trained HRH and ensure return on investments in scholarships (for example, through service requirements for publicly funded students or use of income-contingent student loans, which have been used successfully in other countries). Particular attention will be given to assessing any barriers to women's career progression and remuneration in the health sector. Other activities to be supported will include workshops, seminars, study tours, and consultancies for the development of policies and strategies for health care professionals' careers, progression, and remuneration, as well as the certification of training facilities and accreditation of training programs including for health managers. This subcomponent is aligned with Pillar 4 of the GCRF by contributing to policy and institutional reforms ensuring that the country rebuilds its health system after the COVID-19 pandemic.

24. **Subcomponent 1.2: Curriculum development, regulation, and accreditation (US$3 million).** The scale-up envisaged in the production of additional skilled workers will require that existing training tools and methods are updated. This subcomponent will support the revision or development of existing or new curricula for the various pathways of medical and nursing specialization (focusing on the priority specializations such as family medicine, pediatrics, obstetrics and gynecology, emergency medicine, nutrition, and internal medicine) and their appropriate certification and accreditation. This will include incorporating training on preparedness and response to epidemic, pandemic, social protection, gender, human rights, and climate-related emergencies. The standards, norms, and practices will also provide for continuing professional development for trainers and dual practice, where specialists may also hold lecturer and professor positions. The implementation of this subcomponent will be closely linked with TEST (P179154), which will provide support to enhance the capacity of National Institute for Evaluation and Accreditation of Higher Education (INAAREES) to revise/improve accreditation procedures for health sciences undergraduate-level programs and will incorporate strong elements of gender and rights promotion. The project will also support the development of standards, accreditation, and regulation of designated centers or health facilities for post-graduate training across the country and accreditation of training programs including for health managers. The main inputs to be financed will include information and communication technology (ICT) equipment, consultancies, workshops, seminars, study tours, outreach, supervision and accreditation assignments, stipends, and cross-learning missions. Project funds under this subcomponent will also be used to support in the same manner, similar regulatory bodies for nursing, pharmacy, and other allied health professions to improve their curriculum and regulatory

functions. This subcomponent is aligned with Pillar 4 of the GCRF by contributing to policy and institutional reforms ensuring that the country rebuilds its health system after the COVID-19 pandemic.

25. **Subcomponent 1.3: HRH information management systems (US$6 million).** This subcomponent will invest in establishing a robust HRIMS. The aim is to improve analysis, forecasting, planning, distribution, and management of the workforce. It will also support analytical work that provides information disaggregated by gender, province, professional category and age. This system will shed light in understanding the gender gap in the HRH in Angola, which will be critical to develop the policies necessary to close the gap in the access to post-graduate training. Specifically, this subcomponent will finance the development of: (a) Statements of User Requirements (SOUR) in line with WHO guidance on establishing a HR Observatory;[22] (b) HRH digital architecture and IT development policy leveraging the links with the forthcoming Angola Digital Acceleration Project (P180593); (c) the HRH Digital Information Management System and a dynamic health workforce data platform across all levels of care facilitating links with the new digital initiatives in the country, including approximating resource costs for interoperability with health information systems; (d) the Business Administration and Requirements Manual and protocols; and (e) a dedicated service delivery indicator tracking module (SDI-TM) within the HRIMS to track potential impacts on service delivery at various levels as a result of the direct investments in HRH through the project. It is expected that improved inputs through investments on HRH in Angola aimed at improving capacity in the health sector will eventually contribute to improving service delivery countrywide. While systemwide change will take time to materialize, the project will begin by initially piloting the SDI-TM module in a high-performing province with competent staff and an established track record on quality of services. Based on lessons learned, the module will be incrementally scaled up across the entire health system, with decision-making focalized at the level of the reference centers. The idea would be to periodically (for example, biannually) choose a random number of health facilities across the three different levels of care (primary, secondary, and tertiary) to observe and track a selection of monitorable quality-of-service indicators. More broadly, this will also help expand and strengthen the existing weak evidence base on different dimensions of HRH and their vital nexus with service delivery and quality aspects.

26. The project will also support the recruitment of experts and build technical capacity of professionals to manage, maintain, and supervise the HRH platforms and its cascade to the provinces and in health facilities. The main inputs to be financed will include ICT equipment, workshops, seminars, study tours, outreach vehicles, consultancies, supervision and technical support visits, utilities, subscription or hosting fees, stipends, and cross-learning missions. This subcomponent is aligned with Pillar 4 of the GCRF by contributing to the modernization and capacity building of the public health sector ensuring that the country rebuilds its health system after the COVID-19 pandemic.

Component 2: Training and Capacity Building of HRH (US$175 million)

27. **Subcomponent 2.1: Institutional capacity development for Centers of Reference for Post-graduate Training (US$1.5 million).** The project will support the establishment and strengthening of centers of reference for post-graduate training across the country. The main criteria for selection of the reference centers are: (a) existence of a tertiary-level health care facility; (b) existence of or proximity to

[22] HRH observatories collect, analyze, and disseminate data and information on health workforce and labor market and conduct applied research and produce knowledge. They contribute to policy development, capacity building, and understanding of HRH issues to facilitate dialogue between stakeholders.

a Faculty of Medicine; (c) a strong pool of qualified HRH to train and mentor junior staff; and (d) geographical location to ensure accessibility from other satellite training health facilities. A training facility readiness and needs assessment will be conducted to ensure their readiness for in-person and online training. Based on the report, these facilities will be equipped and provided with upgraded lecture rooms, libraries, skills lab, and simulation facilities to serve as the training-supervision facilities for training sites established in selected provincial and municipal hospitals. The project will also support the acquisition or development of relevant software to manage virtual materials and resources for e-learning and distance education programs. The resources will also be used to train lecturers and tutors in the management of these centers of reference for post-graduate training. Lecturers and tutors will be provided with laptops and computers and each department will be provided with printers, computers, and copiers to enhance their work. To ensure that women have equal access to lecturer and tutor training programs, agreements will be established with universities that train health care professionals to promote the proactive identification of qualified women to be selected. Annual operational budgets will be provided to ensure supervision and outreach support. Other eligible expenses under this subcomponent will include workshops, seminars, study tours, outreach vehicles, consultancies, supervision and technical support visits, utilities, subscription or hosting fees, stipends, and cross-learning missions. This subcomponent is aligned with Pillar 4 of the GCRF by contributing to the capacity-building of the public health sector, ensuring that the country rebuilds its health system after the COVID-19 pandemic.

28. **Subcomponent 2.2: Institutional capacity development for provincial and municipal satellite training centers (US$13.5 million).** The subcomponent will strengthen 27 provincial- or municipal-level health care facilities that are linked to the centers of reference. These satellite facilities will ensure the link between the centers of reference and the provincial and municipal health facilities throughout the country to establish the desired network of post-graduate and in-service training health facilities. These include secondary-level facilities with (a) existence of the key medical and nursing specialties (that is, family medicine, internal medicine, general surgery, obstetrics and gynecology, and pediatrics) and (b) adequate and reliable supply of water, electricity, and telecommunications infrastructure. The facility must also have infrastructure to host external students in rotation from all 18 provinces. Each satellite facility will undergo a readiness and needs assessment, following which the facility will be equipped. This will also include the provision of a standard package of basic medical equipment, hardware, and software to manage e-learning and distance learning materials. A systematic capacity development program will be developed to train identified specialists as adjunct lecturers and preceptors for post-graduate training with an understanding of gender dynamics and its role in health as a key component of the training. Fellowship and student grants will be provided to individuals to be trained at the PhD and masters levels to become specialist lecturers in addition to their fellowship qualifications. To ensure that women have equal access to lecturer and tutor training programs, agreements will be established with universities training health care professionals to promote the proactive identification of qualified women to be selected. Each preceptor will be provided with appropriate laptops and each department will be provided with printers, computers, and copiers to enhance their work. Annual operational budgets will be provided to ensure supervision and outreach support. Other eligible expenses will include workshops, seminars, study tours, vehicles to support outreach, office equipment and furniture, learning support materials, lecture hall decoration, consultancies, supervision and technical support visits, utilities, subscription or hosting fees, stipends, and cross-learning missions. This subcomponent is aligned with Pillar 4 of the GCRF by contributing to the capacity-building of the public health sector ensuring that the country rebuilds its health system after the COVID-19 pandemic.

29. **Subcomponent 2.3: Post-graduate HRH training programs (US$135 million).** This is the main focus of the project and will be tailored toward increasing the number of specialists and post-graduates trained. The subcomponent will support the production of specialty-level clinicians and allied professions including pharmacy and laboratory technology and their sub-specialties. All students admitted into the collegiate specialist or fellowship program and masters or doctoral programs may benefit from this subcomponent. Based on the current needs of the country, the following key medical and nursing specialist programs will be prioritized: family medicine, pediatrics, obstetrics and gynecology, internal medicine, nutrition, emergency medicine, and cardiology. This will ensure that the project strengthens all levels of care, specially at the community and municipal levels with a large cadre of family medicine trained professionals. As far as possible, the training will be undertaken in Angola, with international training limited to only those cases where local training is not feasible. The project will benefit from existing memoranda of understanding (MoUs) with other Lusophone countries such as Portugal and Brazil for post-graduate and specialist training programs. This approach will ensure that, on the one hand, the project will promote inclusiveness by providing equal opportunities to all health workers (removing proficiency in foreign language as key criteria) and, on the other hand, promote sustainability, as these will not be newly established protocols that would require continued World Bank support to be maintained. To prevent brain-drain of qualified HRH, these agreements with other countries will include clauses that preclude them from practicing in these foreign countries. The high cost of this subcomponent is linked with the high costs associated with scholarships (US$1,500 per health professional per month abroad) for international specialty training and fees associated with bringing qualified international specialists, mentors, supervisors, and lecturers. The annual list of specialist and sub-specialty programs and qualifying individuals to be supported by the project will be cleared by the World Bank. To ensure that women health care workers have equal access to post-graduate training programs, agreements will be established with universities training health care professionals to promote the proactive identification of qualified women to be selected. The selected health care professionals who will receive post-graduate, specialist, and in-service training will sign written agreements with the MoH with provisions to ensure that those benefiting from these trainings are mandated to serve for a certain number of years in Angola or be made to repay the costs of the training/education. To ensure that the project actively promotes equity in HRH distribution in Angola, the project will seek to recruit students from rural areas who have finalized undergraduate pre-service training, with a commitment/obligation to return to serve in their own respective rural communities. Emphasis will be placed on gender equity in selection of candidates and an understanding of gender dynamics and its role in health as a key component of selected programs. Persons serving in deprived and climate-related vulnerability areas or for scarce skills areas will be prioritized. The MoH may approve an international training program for specific specialties in consultation with the World Bank. Eligible programs for funding will be those structured to have a duration between six weeks and a maximum of three years at a time. Any individual may only benefit once under the project. The programs must be certifiably linked to a clear progression structure as part of the human resource policy. The qualified program may be offered through a variety of teaching modalities, including in-person specialty programs, in-person continuous health professional education, on-the-job training and professional attachment, and intra- and international e-learning courses and programs. Specific activities to be financed include: (a) travel, accommodation, and fees and stipends to study; (b) fees to mobilize preceptors within the country to support training programs at provincial and community levels; (c) costs associated with workshops and seminars for the review of candidates across the country for training programs; and (d) grants for epidemiological and medical research linked to approved fellowship training. All efforts will be made to ensure representation across genders at all levels of professional training. This

subcomponent is aligned with Pillar 4 of the GCRF by contributing to capacity building of the public health sector ensuring that the country rebuilds its health system after the COVID-19 pandemic.

30. **Subcomponent 2.4: Strengthening the Institute of Specialization in Health (US$7 million).** The project will support the old National School of Public Health (NSPH), which is now an integral part of the abovementioned Institute of Specialization in Health. The Institute of Specialization in Health will be supported to develop curricula for masters and doctoral programs in: (a) health economics, financing, and policy; (b) hospitals management and administration; (c) HRH; and (d) health infrastructure management. An understanding of gender dynamics and its role in health will be incorporated as a key component of curricula. To advance this agenda, resources will be made available to renovate and refurbish the existing infrastructure. Resources will be provided to train and recruit at least four people in each area of specialty at the PhD level to boost faculty for the existing and new programs. An interim measure will be put in place to recruit up to six international experts to assist in the development of accredited curricula for the various areas in collaboration with the Faculty of Medicine at *University Agostinho Neto* (UAN) in Luanda (under the auspices of the Ministry of Higher Education). The IES will be provided teaching and learning support materials and paid fees for each of the students they train under the project. For long-term sustainability, the fees may be based on a cost-sharing basis. For courses that are not available in the IES during the first two years of the project, students may be supported to pursue admission to other national or international institutions, or international faculty may be engaged to deliver the programs in the country. To ensure that women have equal access to masters and PhD training programs, agreements will be established with universities training health care professionals to promote the proactive identification of qualified women to be selected. The investment under this subcomponent will be complementary to the investment made through the forthcoming TEST (P179154), which will aim to establish partnerships between higher education institutes in Angola and Portugal or Brazil. Graduates from these master- and PhD-level programs will be key to support quality improvement processes and activities at the undergraduate level and thus further boost the World Bank's investment through the abovementioned project. This may include: (a) fees for affiliation and to bring foreign professors and academics to Angola to establish in-country training programs; (b) stipends and scholarships for lecturers to study and perform internships abroad; (c) fees to mobilize professors and academics within the country to support training; (d) fees charged by international academic or training institutions for e-learning courses; and (e) workshops and seminars to promote research, academic conferences, and publications. This subcomponent is aligned with Pillar 4 of the GCRF by contributing to capacity-building of the public health sector ensuring that the country rebuilds its health system after the COVID-19 pandemic.

31. **Subcomponent 2.5: Establishment of digital e-learning and provider-to-provider telemedicine platforms (US$18 million).** This subcomponent would support the establishment of national and international networks for distance learning, supervision, and provider-to-provider telemedicine. The telemedicine and distance learning program is expected to have a substantial impact on the cost of specialist care to patients and on greenhouse gas (GHG) emissions by reducing road and air travel within and outside the country. The objective is to improve the provision of care in deprived areas in ways that support access to learning for health staff across gender and various levels of staffing. The creation of provider-to-provider telemedicine services will include the establishment of a planning and oversight Task Force, including the development of a telemedicine adoption strategy and roadmap; evaluation of the minimal technical requirements; and solution design, service provider partnerships, and testing for setting up, implementing, operating, and managing provider-to-provider services. Specifically, the project will finance: (a) a services eligibility and cost-benefit analysis to determine which medical conditions should be included in the initial telemedicine and distance learning program, including an advertising and

demand generation plan for telemedicine services; (b) development of a telemedicine program and distance learning SOUR, developed with a gender lens; (c) the purchase of relevant software and equipment to support the program and virtual simulation; (d) development of a business administration and requirements manual and protocol; (e) training of specialists and technical experts based on standardized guidelines, toolkits, and policies by the host instructing facility; (f) practice insurance fees as appropriate; and (g) fees for distance learning, computer-based instruction, virtual simulation education, consultancies, supervision and technical support visits, utilities, subscription or hosting fees, stipends, and cross-learning missions. This subcomponent is aligned with Pillar 4 of the GCRF by contributing to capacity building of the public health sector, ensuring that the country rebuilds its health system after the COVID-19 pandemic.

Component 3: Project Management and Monitoring and Evaluation (US$10 million)

32. **Subcomponent 3.1: Project management (US$7 million).** The Task Force established by the MoH will function as the project's Steering Committee and will oversee the development of annual work plans and budgets and terms of reference (TOR) and will interact with the key MoH departments and institutions to ensure proper project implementation. Within the MoH, the magnitude and complexity of this project will require a diverse skill set to support project implementation and coordination. To ensure compliance with critical project requirements, the project will: (a) hire a qualified and experienced accountant; (b) employ a treasury assistant; (c) recruit an internal auditor; (d) update and adopt the Project Implementation Manual (PIM); (e) update and customize the computerized accounting software; and (f) no later than six months after project effectiveness recruit the external auditors. The MoH may also, as and when needed, recruit: (a) a project manager; (b) a procurement specialist; (c) an ICT development specialist; (d) a monitoring and evaluation (M&E) specialist; and (e) an environmental and social protection specialist. Furthermore, to further ensure the equity and retention of trained HRH, the PIM will include the following provisions: draft a placement plan for HRH graduates to ensure that underserved communities are prioritized and template for the signed agreement between the MoH and the selected health care professionals with the specific clauses, provisions, and penalties to ensure retention of civil servants in the public sector and in the locations assigned. Lastly, the PIM shall include aspects related to the sequencing of specific project activities, such as the development of the HRH Development Plan or the service delivery quality tracker within the HRIMS, to ensure effective implementation based on a streamlined stepwise approach to activities. The project will also support the operations of the Project Implementation Unit (PIU) and the participation of staff from the MoH in technical discussions to ensure effective implementation and management of the project. This will include workshops, seminars, conferences, office equipment and furniture, vehicles, consultancies, supervision and technical support visits, study tours, utilities, subscription or hosting fees, stipends, and cross-learning missions.

33. **Subcomponent 3.2: Monitoring and evaluation (US$3 million).** This component will focus on all aspects related to project M&E, knowledge generation, and communications. It will support activities at the national, provincial, and municipal levels to: (a) institutionalize and sustain continuous performance-based targets setting and reporting; (b) set up a scorecard system and train staff on its use to measure performance at all levels; (c) report on all key indicators of the project, conduct and report on mid-year, annual, and midterm reviews in consultation with other development partners and civil society; and (d) publish the results. This project will also support the MoH in liaising with the National Statistics Institute and get its support to validate the Results Framework indicator data and progress in HRH post-graduate training in Angola. In all M&E, emphasis will be placed on gender, social protection, and rights issues. Eligible expenses will include training workshops, seminars, vehicles to support outreach, office

equipment and furniture, consultancies, supervision and M&E visits, utilities and fuel, subscription or hosting fees, stipends, and cross-learning missions.

Component 4: Contingent Emergency Response Component (CERC) (US$0)

34. This CERC is included under the project in accordance with World Bank's Investment Project Financing Policy, paragraphs 12 and 13, for situations of urgent need of assistance. This will allow for rapid reallocation of project proceeds in the event of a natural or man-made disaster or health outbreak or crisis that has caused or is likely to imminently cause a major adverse economic and/or social impact. To trigger this component, the Government needs to declare an emergency or provide a statement of fact justifying the request for the activation of the use of emergency funding. To allocate funds to this component, the Government requests the World Bank to reallocate project funds to support emergency response and recovery. Disbursements would be made against an approved list of critical goods, services, and works required to support the immediate response and recovery needs. A CERC Operations Manual will be prepared as an annex to the Project's Implementation Manual outlining triggers for its activation and detailing fiduciary, E&S, and any other necessary implementation arrangements.

C. Project Beneficiaries

35. The project will cover all 18 provinces of Angola and the primary beneficiaries will be the 29,000 healthcare professionals (approximately 30 percent of eligible civil servants' health workers)[23] being prioritized for specialist, post-graduate, or in-service training in Angola: 3,000 doctors, 4,000 nurses, 4,000 diagnostic and therapeutic technicians, 9,000 assistant nurses, and other 9,000 general service staff and health support professionals. By establishing a robust training network for health care professionals, the project will expand capacity building and professional growth opportunities for the entire health workforce in country. With improved training, the project is expected to improve health care service delivery to the entire Angola population, which will benefit indirectly from this project's investment.

D. Results Chain

36. The proposed operation will invest in the key areas of HRH through the projects key three components. The first components by investing in governance, curricula and information systems to address the challenges of lack of good quality HRH data, adequate policies for retention and distribution, appropriate curricula and will create the policy level foundations for a functioning HRH training program in Angola. Through the second component of the project, by investing in establishing a HRH training network in Angola and funding the provision of in-service, postgraduate, and specialist level training within and outside the country. This robust training program Through the third component, investments will be made to strengthen the institutional capacity at National, Provincial and Municipal level for the implementation and sustainability of the HRH training network. Through the three project components, the project will support the country to create a robust HRH training program and generating a pool of high-quality trained HRH, thus improving the capacity and availability of HRH in Angola. This will lead to improved access to quality services that are adequate to the Angolan needs and getting the country closer to universal health coverage. Figure 6 describes the Theory of Change in further detail.

[23] The estimated number of total eligible civil servants' health workers is 96,000.

Figure 6. Theory of Change

Key challenges | Activities | Outputs | Outcomes (Short Term, Medium-term, Long-term)

1.HRH Governance, Policy, Curricula and Information

Key challenges

1.Lack of documented HRH data to develop policy and plans to guide HRH development and reforms

2.Inadequate HRH policies, legislation, and governance

3.Inadequate HRH information Management System

Activities

a) Diagnostic assessment of HRH needs and development 10-year HRH National Development Plan;
b) Support defining key HRH policies (production, distribution and retention);
c) Support curriculum development, regulation, and accreditation;
d) Establishment of HRH digital information system in line with WHO requirements

Outputs

a) Evidence informed plans, policies, and information systems to manage HRH
b) Improved HRH Policies
c) Improved and accredited post-graduate curricula
d) Established digital HRH management System

2.Training and capacity building of HRH

Key challenges

1.Weak institutional capacity to deliver post-graduate, specialist level and in-service trainings.

2. Limited number of national specialized health professionals

3. High cost with expatriate health professionals

4. Absence of e-learning opportunities for decentralized areas

Activities

a) Institutional capacity development for Centers of Excellence for Post-graduate training.
b) Institutional development of Provincial and Municipal satellite training centers;
c) Post-graduate HRH training programs;
d) Strengthening the National School of Public Health;
e) Establishment of digital e-learning and training platforms;

Outputs

a) Increased supply and competence of HRH at all levels of care across the country
b) Strengthened capacity of provincial and municipal satellite centers to build HRH capacity
c) Increased opportunities for post-graduate and in-service training for HRH at all levels of care

3.Project Management, Monitoring and Evaluation

Key challenges

1.Limited capacity of the MOH to comply with Bank's fiduciary and safeguards requirements and effective project management

2.Lack of ICT equipment and skills to perform adequate monitoring and evaluation of the HRH training network

Activities

a) Promote national and sub-national coordination of activities;
b) Build capacity for the mentoring, supervision, institutionalization, and sustainability of the HRH training program network.

Outputs

a) Strengthened capacity for project coordination, monitoring and supervision at national, provincial, and municipal levels
b) Assured quality of HRH training delivery

Outcomes

Short Term: Robust HRH Training Program established in Angola

Medium-term: Improved capacity and availability of Human Resources for Health in Angola

Long-term: Improved access to the quality services adequate to Angolan needs, when and where they need them, without financial hardship

E. Rationale for Bank Involvement and Role of Partners

37. **Several development partners have specific health programs in Angola.** The major ones are the Cuban cooperation, the European Union, the Global Fund, USAID,[24] GAVI Alliance for Vaccines, JICA,[25] and United Nations agencies. In addition, there are active partnerships with civil society organizations and private sector entities, including oil companies, and regional organizations. These partners are providing relevant technical and financial support to the Angolan health sector, consistent with the national priorities defined in PNDS (2012–2025). The majority of these investments provide targeted and evidence-based interventions for malaria, family planning, reproductive health, and most recently COVID-19. The overarching goal is to improve access to quality health care and promote behavior change, by strengthening local capacity to deliver integrated services across different levels of the health system. None of these partners target post-graduate specialty training and institutional capacity development.

38. **Given budget constraints, the ambitious HRH agenda of the Angolan Government will require the World Bank's support for its realization.** Significant resources will be needed to fund the scale-up in production, equitable distribution, and management of specialty post-graduates. The World Bank will work with the Government and other stakeholders to: (a) support the generation of evidence-based policies on HRH to optimize their production, performance, quality, and effectiveness; (b) finance the training of individuals and faculty to meet the projected needs; (c) support improvement in the capacity of training institutions and facilities at the national and subnational levels; (d) invest in IT to establish information systems for adequate management of HRH data, strengthen e-learning platforms, and institutionalize telemedicine. All these will need to be done sustainably, inclusively, and equitably, leveraging the opportunities to increase efficiencies in the health sector while promoting gender equity, data integrity, and sustainable human capital development.

39. **The project will build synergies with other World Bank-financed projects and donor-financed activities supporting the health sector.** Specifically, the project will coordinate with the forthcoming Education Project (TEST, P179154) and the recently approved Angola Strengthening Governance for Enhanced Service Delivery Project (P178040)—which focuses on increasing civil registration and identity coverage. It will collaborate with the forthcoming Angola Digital Acceleration Project (P180693), to ensure alignment and integration with the investments in digital HRH management platforms and telemedicine systems. The project will also work closely with relevant United Nations agencies and bilateral development partners to define focused technical assistance in line with the WHO's Global Strategy on HRH: Workforce 2030.[26]

F. Lessons Learned and Reflected in the Project Design

40. **The World Bank has implemented previous projects with the MoH.** The following projects are currently under implementation: the Health System Performance Strengthening Project (HSPSP) (P160948) and the GAVI Additional Financing for Child Health Expansion Angola (P168956), the Fourth Phase of the Regional Disease Surveillance Systems Enhancement (REDISSE IV) Project for Central Africa

[24] USAID = United States Agency for International Development.
[25] JICA = Japan International Cooperation Agency.
[26] WHO. 2016. *Global Strategy on Human Resources for Health: Workforce 2030.* https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf.

(P167817), and the Angola COVID-19 Strategic Preparedness Response Project (P176630). The objectives of these projects were to strengthen national and regional cross-sectoral capacity for collaborative disease surveillance and epidemic preparedness and provide immediate response to eligible crises or emergencies. During the implementation of the REDISSE Project in Angola, the project supported the establishment of a One Health[27] Platform for coordination of project activities across different sectors—health, agriculture, and environment. Considering the success of this MoH-led platform, the World Bank agreed with the MoH to have this platform function as the REDISSE Angola Steering Committee, which is currently responsible for drafting and approving annual work plans and budgets, reviewing TOR, and overseeing technical implementation of the project. To decrease costs in the implementation of World Bank-supported projects, a single PIU, the Central Coordinating Unit (*Unidade Central de Coordenação*, UCC), is responsible for managing all three projects. However, it is to be noted that, when the UCC grew to manage the implementation of the three aforementioned projects, the staff also grew, which forced the PIU to rent an expensive office space in the suburbs of Luanda—Talatona. However, after strong lobbying from the World Bank, the MoH found office space within one ministerial building, and the UCC has moved in May 2023. This will be a significant cost-saving for the implementation of the World Bank-financed health sector portfolio and an important lesson to learn for the implementation of future operations in Angola. Most of these projects saw a slow start to the planning and implementation of activities as the responsibility for implementing multiple projects simultaneously overwhelmed the PIU, and the key focal points at the MoH were the same for all three projects. Based on these experiences, and besides a strong technical team overseeing project implementation, the UCC shall identify the procurement and financing staff to be exclusively dedicated to this project. At a minimum, this should include a procurement assistant/specialist, a financial management (FM) assistant/specialist, and an M&E assistant/specialist.

G. Alignment with Corporate Commitments

Gender

41. **The Angolan Government has ratified the international human rights treaties and subscribes to the African Union and the South African Development Community Gender Equality Mechanisms.** It adopted the National Plan for implementation of Resolution 1325 of the United Nations Security Council on Women, Peace, and Security (2016–2018), and the national constitution amended in February 2010 provides for the protection of human rights and freedoms. The Family Code (Law no. 1/88) and the Law against Domestic Violence (Law No 25/11) provide for shared responsibility for family life with appropriate penalties for GBV. Though implementation of these provisions in law and resolution has been slow, there are signs of progress. In February 2021, a penal code was introduced that decriminalized same-sex relations and introduced orientation protections.

42. **The project components include targeted interventions to improve women health care workers' access to post-graduate training, which will lead to improved career progression.** Specifically, this project will support three main actions to achieve these objectives: registration of female health care workers in the HRIMS to get better data to further characterize the gender gap in HRH in Angola; assessment of the barriers for women to access post-graduate training and career progressions and development of an action plan to be included in the HRH Development Plan; and establishment of

[27] One Health is an integrated, unifying approach to balance and optimize the health of people, animals, and the environment.

agreements with universities that train health care professionals to ensure that at least 50 percent of post-graduate health care workers benefitting from this project are women.

(a) The data being entered in the HRH information system will be disaggregated by gender and thus will allow for an in-depth assessment of the gender disaggregation of HRH in Angola. This assessment will allow to understand the distribution of women across the different professional categories, education and training levels, geographic locations, and age. To ensure women's access to registration on the platform, the project will promote gender-responsive approaches in communications strategies for the public, including use of multiple accessible mediums in local languages, use of targeted messaging, and creation of responsive platforms for registry of inquiries and grievances.

(b) Assessments at the national and provincial levels will be undertaken to understand the root causes and barriers to women's access to post-graduate training and career progression after receiving the required trainings. This assessment will inform the development of an action plan to be included in the HRH Development Plan being funded by the project.

(c) To ensure that women have equal access to the different activities of this project, agreements will be established with universities that train health care professionals to promote the proactive identification of qualified women to be selected for such training opportunities. For Subcomponents 2.1 and 2.2, these agreements will ensure that women have equal access to lecturer and tutor training programs provided at the centers of reference and satellite health facilities. For Subcomponent 2.3, these agreements will ensure that women health care workers have equal access to post-graduate training programs. For Subcomponent 2.3, these agreements will ensure that that women have equal access to masters and PhD training programs.

43. To measure progression on the proposed activities, the following sub-indicators have been included in the project's Results Framework:

(a) **PDO level** - Number of women health care workers with certified post-graduate level training

(b) **Intermediate indicators** - Percentage of women health care workers registered in the HRH platform in all 18 provinces; Number of women qualified mentors and supervisors in Centers of Reference to train and mentor junior staff; and Number of Provinces that have conducted assessments to identify entrenched gender gaps for HRH strengthening and developed the inclusion of remedial activities in the HRH Development Plan.

Data Protection

44. **The Angolan data protection regime explicitly extends to health-related data, and the regime is actively implemented and regulated by the Angolan Data Protection Agency (APD), established in 2016.** According to data protection legislation (Article 14), data related to health and sexual life, including genetic data are considered sensitive, meaning that the protection of that data is of heightened importance and may only be processed with expressed agreement of the individual, its legal representative, or authorization of the APD. Under the law, a licensed health care professional does not need to obtain the consent of the data subject (that is, the patient) if the processing of personal data is done for preventive medicine, medical diagnostic, medical care, medical statistic, medical emergency, or

public interest. They are however required to keep data they collect secure in the process of performing their duty. Any unlawful disclosure of personal and private information not consistent with the provisions of the law attracts a fine of between US$75,000 and US$150,000 equivalent in Angolan kwanza. Misuse or abuse of data protection policy are to be reported to the Agency. While the law ticks many boxes on data protection, public awareness is low, and the reporting mechanisms are not always simple. All digital interventions under this project will aim to support the country in reaching internationally acceptable standards in data protection and privacy. The project will support the Government's efforts to create awareness concerning data protection and train relevant staff to be compliant with international and national standards and requirements in performing their functions.

Climate Change

45. **The project has been screened for climate disaster risks and has been found to be highly exposed to climate risks, including floods and droughts, while the risk to project activities has been found to be moderate.** Floods were the highest occurring hazard, approximately 55.13 percent of all hazards, between 1980 and 2020. In the first part of the twenty-first century, floods devastated the cities of Ondjiva, Luanda, Benguela, and Namibe, where water overwhelmed houses and commercial buildings and disrupted transportation for extended periods. Since 2018, floods have affected about 70,370 people in Angola. Rural areas are also highly vulnerable to flooding, as many residents live on riverbanks, leading to loss of possessions and crops and increasing the risk of water borne diseases. Droughts have also affected people in Angola, with approximately 3.8 million people being affected by droughts in 2020 and 1.4 million in 2017. Recent cycles of droughts and floods in the southern provinces have caused an estimated US$242.5 million in agricultural losses, severely affecting the estimated 40.5 percent of the population living below the poverty line, including target beneficiaries of this project. Further, sea level rise poses a major threat to its coastal population, where it is estimated that 50 percent of Angolans reside. The coastal areas in the country experience lower rainfall than inland areas and are vulnerable to sudden storms.[28] Projected changes in temperature and rainfall are likely to increase the frequency and severity of these climatic events, all of which have the potential to affect the project's target population. Mean annual temperature is projected to increase between 1.2 and 3.2°C by 2060 and 1.7 and 5.1°C by 2090, with warming expected to increase more rapidly in the interior and eastern parts of the country. Projected changes in precipitation vary, with some estimates indicating changes in median annual rainfall ranging from –1 to –6 percent by the 2090s.

46. **Additionally, climate change hazards have an impact on the health of Angolans.** There is evidence of the link between climate and cholera as evidenced by a seasonal pattern of increased risk of cholera between 2010 and 2016 in the country.[29] In 2016, heavy rains combined with uncollected garbage contributed to higher cases of diarrhea in Luanda.[30] Climate change and hazards have increased the risk of vector-borne diseases in the country, namely malaria. Projections show that climate change will increase the length of the malaria transmission season in the central parts of the country by 2080.[31] Transmission of malaria in more low-lying areas is projected to increase after periods of heavy rainfall. Shifts in temperature will alter the risk of malaria transmission and vector suitability—250,000 additional

[28] Academia. A. Cain. 2017. Climate change and land markets in coastal cities of Angola.
[29] J Perez-Saez. The seasonality of cholera in sub-Saharan Africa: a statistical modelling study. The Lancet Global Health, Volume 10, Issue 6, 2022
[30] USAID. CCIS Project Climate Risk Profile Angola. 2018.
[31] Ryan SJ, Lippi CA, Zermoglio F. Shifting transmission risk for malaria in Africa with climate change: a framework for planning and intervention. Malar J. 2020 May 1;19(1):170.

people, mainly in the western provinces, will be at risk of malaria by 2030.[29] In 2016, Luanda experienced a yellow fever outbreak. The second wave (March–April) was found to be associated with the El Niño phenomenon, which created ideal breeding conditions for the vectors. Another study revealed a high transmission risk of Zika in Angola due to the El Niño. Droughts and floods have affected food security in the country by affecting agriculture productivity.[32] Climate change projections over the second half of the twentieth century show a shorter crop growing season due to delayed start of rainfall and shorter periods of rainfall.[33]

47. **The GoA is committed to addressing climate change.** The National Adaptation Programme of Action (NAPA) (2011) communicates the countries' climate adaptation needs and includes objectives to strengthen the national capacity in climate resilience.[34] The NAPA highlights that floods are the highest climate hazard threat to human health, followed by heat waves. In 2012, the National Committee on Climate Change and Biodiversity was created under the Minister of Environment. The committee is tasked with harmonizing programs and policies and creating the necessary conditions for the implementation of a National Climate Change Plan. Climate change has been integrated into broad national strategies through the 2013–2017 National Development Plan under the framework of the new Constitution of Angola. Angola has yet to ratify the Paris Agreement; however, the country's intended Nationally Determined Contribution (2015) is aligned to the National Strategy for the Implementation of UNFCCC[35] and the Kyoto Protocol. Angola intends to reduce GHG emissions by 35 percent by 2030. Additionally, one of the pillars of Angola's Country Partnership Strategy with the World Bank stresses enhancing the quality of health services; protecting vulnerable and marginalized citizens; and building resilience to potential shocks, including those attributable to climate change. Further, the country's 2022 Angola Climate Change Development Report included a deep dive on the health sector, which included identification of prioritized health climate adaptation actions. Angola also has a National Strategy for Climate Change (2018–2030),[36] a National Strategy for Food and Nutrition (2010–2025),[37] and a Strategic Plan for Disaster Risk Management (2011).

48. The project intends to implement measures to adapt to climate change and mitigate GHG emissions, as outlined in table 1.

Table 1. Adaptation and Mitigation Measures

Subcomponent	Climate Action
Component 1: HRH Governance, Policy, Curricula, and Information Systems (US$15 million)	
Subcomponent 1.1: HRH Governance Systems and Policies (US$6 million)	**Adaptation:** Climate vulnerability will be included in the formula for health worker distribution. Climate vulnerability will be identified through climate vulnerability maps for the country, vulnerability level will be assigned a weight, and increased vulnerability will be used to assign additional health workers to climate vulnerable areas, based on this vulnerability level. **Adaptation:** Climate vulnerability will be included in the formula for health worker retention packages. Climate vulnerability will be identified through climate vulnerability maps for the country, vulnerability level will be assigned a weight, and

[32] Care. 10 humanitarian crises that didn't make headlines in 2022.
[33] Codespa. Soy Production and Agricultural Systems for Small Producers in the Province of Huambo, Angola.
[34] Angola national adaptation programme of action under the United Nations Framework Convention on Climate Change 2011.
[35] UNFCCC = United Nations Framework Convention on Climate Change.
[36] Estrategia Nacional para as alterações climaticas Angola 2018-2030.
[37] Angola. National Strategy on Food and Nutrition Security (2010-2025)

Subcomponent	Climate Action
	health workers retention package will be increased based on the level of vulnerability to help retain health workers in these climate vulnerable areas. **Adaptation:** As part of this subcomponent a climate emergency response contingency deployment plan for health workers will be developed. This document will outline deployment plans for health workers in response to climate shocks and emergencies. Specific attention will be paid to different types of climate shocks (high heat, floods, and droughts) in Angola's context and plans for different geographic locations and needs at different levels of the health system as well as the community. These actions will help ensure adequate numbers of health workers in climate vulnerable areas, helping to adapt to the health impacts of climate change.
Subcomponent 1.2: Curriculum development, regulation, and accreditation (US$3 million)	**Adaptation:** Climate emergency preparedness and response and climate adaptation in the health system will be incorporated into curriculum development under this subcomponent. The curriculum will focus on Angola's climate vulnerabilities, including drought, floods, and high heat, and will include specific modules on health system adaptation to climate change including expected impacts on disease burden and infrastructure as well as actions, along with training on climate emergency preparedness and response. This will help the country adapt to the health impacts of climate change.
Component 2: Training and capacity building of HRH (US$175 million)	
Subcomponent 2.1: Institutional capacity development for Centers of Reference for Post-graduate Training (US$1.5 million)	**Adaptation:** This subcomponent will implement the climate emergency preparedness and response training, utilizing the curriculum developed in Subcomponent 1.2. This will help the country adapt to the health impacts of climate change.
Subcomponent 2.2: Institutional capacity development for provincial and municipal satellite training centers (US$13.5 million)	**Adaptation:** Fees and research grants for students will be prioritized to health workers from climate vulnerable areas. Climate vulnerability will be identified through climate vulnerability maps for the country, vulnerability level will be assigned a weight, and increased vulnerability of the facility in which the health worker/student works will be used to assign additional weight to their application, for priority receipt of fellowships and grants. This will help ensure that well-trained health workers are placed in climate vulnerable areas, contributing to climate change adaptation. **Adaptation:** This subcomponent will also implement the climate emergency preparedness and response training, utilizing the curriculum developed in Subcomponent 1.2. This will help the country adapt to the health impacts of climate change.
Subcomponent 2.3: Post-graduate HRH training programs (US$135 million)	**Adaptation:** Fellowships and grants for students will be prioritized to health workers from climate vulnerable areas. Climate vulnerability will be identified through climate vulnerability maps for the country, vulnerability level will be assigned a weight, and increased vulnerability of the facility in which the health worker/student works will be used to assign additional weight to their application, for priority receipt of fellowships and grants. This will help ensure that well-trained health workers are placed in climate vulnerable areas, contributing to climate change adaptation. **Adaptation:** Training programs and workshops will be prioritized for climate vulnerable areas. Climate vulnerability will be identified through climate vulnerability maps. Climate vulnerable locations will receive priority for workshops and training programs, ensuring that all climate vulnerable areas receive workshops and training programs and that these areas receive priority for follow-up training and workshops.

Subcomponent	Climate Action
	This will help ensure that health workers in climate vulnerable areas are well trained and of high capacity, contributing to climate change adaptation. **Adaptation:** This subcomponent will also implement the climate emergency preparedness and response training, utilizing the curriculum developed in Subcomponent 1.2. This will help the country adapt to the health impacts of climate change.
Subcomponent 2.4: Strengthening the Institute of Specialization in Health (US$7 million)	**Adaptation:** Rehabilitation and refurbishment of building infrastructure will include climate adaptive measures to adapt to floods, high heat, and drought. These include: (a) low flow taps to reduce water use; (b) drainage ditches and protective measures for buildings beyond standard practice to reduce the risk of flooding; (c) measures to secure roofs in the event of heavy rains to reduce leaking; and (d) passive cooling measures to reduce heat exposure. This will help the training institutions adapt to the impacts of climate change. **Adaptation:** This subcomponent will also implement the climate emergency preparedness and response training, utilizing the curriculum developed in Subcomponent 1.2. This will help the country adapt to the health impacts of climate change.
Subcomponent 2.5: Establishment of digital e-learning and training platforms (US$18 million)	**Mitigation:** The transition to health worker training through e-learning is expected to result in a substantial reduction in GHG emissions, which is greater than 20 percent, (739.2 CO2eq total fewer emissions from 752.4 CO2eq generated through in-person training to 18.1 CO2eq through virtual training, annually, see footnote for assumptions)[38], as demonstrated by calculations of GHG emissions averted based on global and country evidence.[39] This move from in-person to digital training is projected to avert 30,000 car (60 percent) and plane (40 percent) trips annually, each estimated to be cover 200 km. Further, this is the first phase of an ongoing training digitization process in the country, which is planned to be extended to approximately 100,000 health workers. **Mitigation:** The telemedicine program, which will connect health workers with each other, is a new intervention that will increase the points of contact between health workers. While this intervention primarily does not replace most health visits (with

[38] Annual estimates for reduced emissions are: Plane emissions are estimated at 135.7 g CO2eq/person-km and car emissions at 118.6 g CO2eq/person-km. Total metric ton CO2eq emissions for cars are estimated at 325.6 CO2eq and 426.8 CO2eq for planes, for a total of 752.4 CO2eq. Total energy use for in-person learning is estimated at 4.8 CO2eq. This is based on 15,000 people receiving 6 hours of training at 71.4 Wh/person-hr with an electricity use emissions factor of 0.748 g CO2eq/Wh. In contrast, emissions from virtual training are expected to generate 8.5 g CO2eq/person-hr for video conferencing (60 percent of virtual trainings) and 9.6 g CO2eq/person-hr for video streaming (40 percent) for 15,000 people for 6 hours, resulting in a total of 18.1 CO2eq. Total in-person emissions are estimated at 752.4 CO2eq while total virtual emissions are estimated at 18.1 CO2eq, resulting in a 739.2 CO2eq reduction in emissions from virtual trainings.

[39] Purohit A, J. Smith, and A. Hibble A. 2021. "Does Telemedicine Reduce the Carbon Footprint of Healthcare? A Systematic Review." Future Healthcare Journal 8 (1): e85–e91. doi: 10.7861/fhj.2020-0080. PMID: 33791483; PMCID: PMC8004323.
Grid emission factor estimate: https://unfccc.int/documents/437880
Classroom Energy Use (Primarily Lighting and Air Conditioning) Estimate: J.A. Samuels, S.S. Grobbelaar, M.J. Booysen, Light-years apart: Energy usage by schools across the South African affluence divide, Energy Research & Social Science, Volume 70, 2020, 101692, ISSN 2214-6296, *https://doi.org/10.1016/j.erss.2020.101692*
Video Conferencing Energy Use Estimate: Renee Obringer, et al. The overlooked environmental footprint of increasing Internet use, Resources, Conservation and Recycling, Volume 167, 2021, 105389, ISSN 0921-3449, *https://doi.org/10.1016/j.resconrec.2020.105389*
Economy Flight Emissions Estimate: *https://applications.icao.int/icec/Methodology%20ICAO%20Carbon%20Calculator_v11.1-2018.pdf*
Car Emissions Estimate: Fédération Internationale de l'Automobile, Promoting Safer and Cleaner Used Vehicles for Africa, 2020

Subcomponent	Climate Action
	the exception of some tertiary consultations), it is planned as the basis for the expansion of telehealth visits in the country, replacing many in-person consultations over time, with an anticipated substantial impact on GHG emission reductions.
Component 3: Project Management, Monitoring and Evaluation (US$10 million)	
Sub-component 3.1: Project management (US$7 million)	**Adaptation and mitigation:** This subcomponent will manage the project's climate activities and as such should be assessed at the same rate as the project's other climate activities.
Sub-component 3.2: Monitoring and evaluation (US$3 million)	**Adaptation and mitigation:** This subcomponent will monitor the project's climate activities and as such should be assessed at the same rate as the project's other climate activities.

Citizen Engagement

49. **The project will have a beneficiary-oriented design and will focus on ensuring access, affordability, and use of primary health care services by the most vulnerable.** While this will be defined contextually, it is likely to include the following categories: urban and rural poor; those living in remote areas; and, women and girls, especially among the poor. The project will include two citizen engagement approaches. The first citizen engagement approach would be consultation, which will encompass all beneficiaries, not only in the context of the World Bank Environmental and Social Safeguards Framework (ESS10) implementation, but during the entire project life cycle (preparation, implementation, and closing). The consultation activities will ensure citizen engagement across vulnerable and non-vulnerable groups, with information regularly conveyed to the project beneficiaries on how the feedback was taken into consideration. The second citizen engagement approach is grievance redressal, which will be designed to process concerns and questions from project beneficiaries and other stakeholders at various levels and will be detailed in the PIM. An indicator will be included to measure and track citizen engagement.

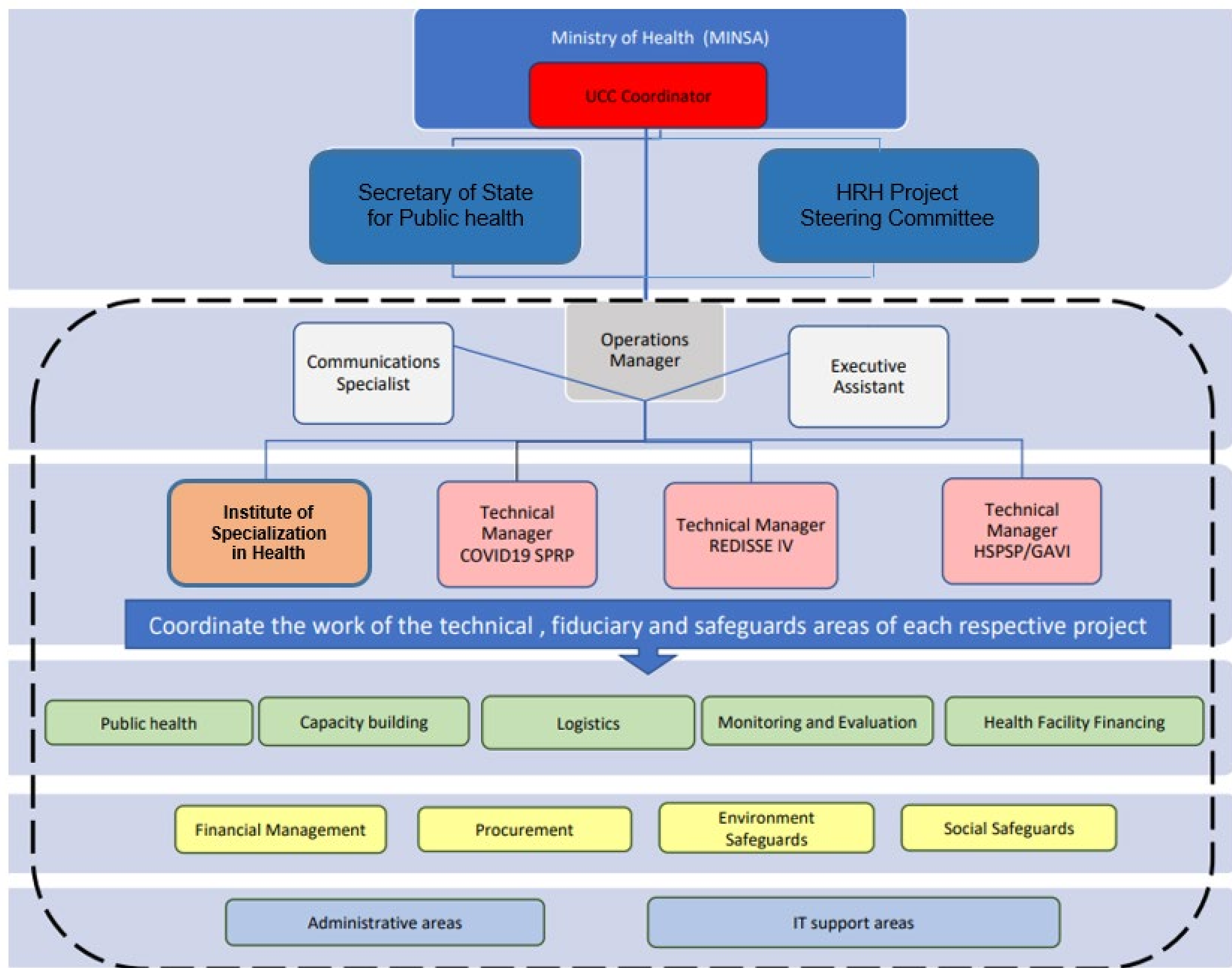
III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

50. **The MoH is the primary beneficiary and implementing agency for this project.** The Task Force, headed by the Secretary of State for Public Health, which has been established to oversee a program of post-graduate training for health care professionals, will function as the project's Steering Committee and will oversee the development of annual work plans and budgets, interim financial reports (IFRs), technical semiannual reports, audit reports and reviews, intersectoral/departmental collaboration, and clearances. This approach is in line with the successful One Health Platform that works as the Steering Committee for the Angola REDISSE Project, as described in paragraph 39. Additionally, the Institute of Specialization in Health will be the key technical implementing agency working in collaboration with the UCC. The UCC leads the implementation of World Bank-financed health sector investments in Angola and will be responsible for project management and fiduciary functions for the project. The UCC is fully staffed with people well-experienced in managing World Bank-financed projects. The UCC is currently led by an operations manager and supported by technical, fiduciary, and administrative staff overseeing operations related to the HSPSP, the GAVI Additional Financing, the REDISSE IV Regional Project, and the COVID-19 operation. The capacity at the MoH and UCC will be bolstered through: (a) additional technical assistance

for the key aspects and components of this HRH strengthening project; (b) additional fiduciary and E&S assistants at the UCC to ensure continued good performance in these key areas; and (c) additional consultants as required in key MoH directorates and provincial-level health departments, including for public health, National Directorate for HRH, and Institute of Specialization in Health. All the human resources for this project implementation will be hired using procurement and recruitment processes in line with World Bank guidance and procedures. Figure 7 highlights the implementation arrangement agreed for this project.

Figure 7. Implementation Arrangements



51. **The FM and disbursement arrangements in place for the Angola health portfolio will apply to the proposed operation.** The UCC will have overall fiduciary responsibility for implementation of the proposed project. The current FM team (consisting of one FM specialist and four assistants and accountants) will be further strengthened with the recruitment of one FM assistant and one accountant, and will have overall responsibility for project's FM. The project funds, expenditures, and resources will be accounted for using a computerized accounting software and the accounting will be on a Financial Reporting under Cash basis. The PIU/MoH will prepare quarterly unaudited IFRs and provide these reports to the World Bank within 45 days of the end of each calendar quarter. The project financial statements (covering all project funds and expenditures) 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 (June 30) of the following year.

52. **The procurement arrangements for the project will be managed by the UCC team.** The UCC includes a procurement specialist, one procurement officer, and three procurement assistants. The team that will support this operation is the same as the one currently responsible for the procurement function under the active health projects (HSPSP, REDISSE IV, and COVID-19 SPRP), with the addition of one procurement assistant. Procurement under the project will be carried out in accordance with the World Bank's Procurement Regulations for IPF Borrowers, dated November 2020. During project preparation, a Project Procurement Strategy for Development (PPSD) document was prepared by the borrower, with the World Bank's support.

53. **The UCC will manage environmental and social risks under the project.** The UCC will maintain the experts currently managing the Environmental and Social Framework (ESF) (REDISSE IV Project [P167817] and COVID-19 SPRP [P176630]) and will recruit an additional social development assistant to support project implementation. The environmental and social performance is currently rated Satisfactory across the portfolio.

B. Results Monitoring and Evaluation Arrangements

54. **Overall project progress and implementation tracking will be steadily monitored throughout the life of the project.** A detailed Results Framework is included in section VIII. Data to monitor progress toward achieving the PDO and intermediate indicators will be collected through dedicated platforms developed to focus on HRH aspects relevant to the project. Given the project's overall scope and in-depth HRH focus and national coverage, the project will develop a well-defined and detailed M&E strategy within the first six months after effectiveness. This will ensure that a clear roadmap and a robust M&E implementation plan are in place, supplemented by extensive training with a particular focus on HRH, to guide and strengthen M&E efforts at the various levels of the health system

55. **Monitoring will also focus proactively on tracking gender through studies and assessments where appropriate, including an analysis of entrenched gender gaps in population access and the use of universal health coverage, as well as in the hiring, training, deployment, and retention of HRH, both nationally and in the project provinces and communities.** The Results Framework will include specific indicators, including gender disaggregation where applicable, to track the efforts made through the project in closing identified gender gaps. Considering recent legislation to expand the administrative division in Angola, indicator disaggregation will be maintained at the provincial level. Depending on how the administrative division process unfolds, the disaggregation approach would be revisited during implementation to include the municipal level. As part of the midterm review, a detailed process evaluation will be undertaken to draw key lessons and identify main barriers to the implementation and achievement of project results. The resulting findings will inform discussions with stakeholders and contribute to course corrections as needed for the remainder of the project.

56. **The project will invest in digital innovation to strengthen M&E of HRH by developing a dedicated HRH information system to collect data on HRH across all levels of care, facilitate linking with the new digital initiatives in the country, and ensure gender disaggregation of data.** Data from proposed e-registries will help track health workforce stock, education, distribution, flows, capacity, and remuneration. Additional technical capacity building will ensure adequate training of health professionals

responsible for routine handling and management of health data to establish, maintain, and supervise the HRH platforms. Given the limited data currently available on HRH in Angola, it is expected that the various project activities and systems envisaged will contribute to strengthen the overall evidence base on HRH in Angola.

57. **The M&E function will reside within the PIU (UCC), which is well experienced in managing World Bank-financed projects.** The UCC will have an experienced and dedicated M&E specialist with some experience in HRH interventions and digital innovations in the health sector. The specialist will be responsible for routine coordination on all aspects related to data monitoring and will provide periodic updates on the project Results Framework. Through frequent mentoring and supervision, the M&E function will also aim to strengthen the overall institutional capacity at the national, provincial, and municipal levels for collecting routine HRH data to promote longer-term sustainability beyond the project. The M&E specialist will also be responsible for periodic reporting to the World Bank on M&E progress and providing assistance with the coordination of studies, assessments, and related initiatives associated with project activities that are relevant to the larger operational evidence base of the project (for example, updating the health sanitary maps, geospatial studies, impact assessment studies, and so on)

C. Sustainability

58. **Sustainability of project results** will be achieved by focusing on strengthening the leadership and governance capacity of the health workforce; strengthening HRH regulatory capacity; optimizing the utilization, retention, and performance of the available health workforce through HRIMS; and embedding cross-sectoral priorities in collaboration with private sector investment. Measures include the following:

(a) Development of a 10-year HRH strategy and action plan that will ensure sustainability of the HRH revitalization financed by this project

(b) Curriculum development, regulation, and accreditation that will outlive the project and will ensure that health care workers will continue to receive high-quality training

(c) Support for the drafting and approval of policies that lead to filling of the staffing needs gaps, particularly in poor and climate vulnerable areas; career progression; and remuneration

(d) Establishment of provisions to ensure retention of the health care professionals who receive post-graduate training with this project’s support

(e) Establishment and strengthening centers of reference for the specialist and post-graduate training of health care workers, which will establish a sustainable platform that can be leveraged by private-public partnerships thus increasing long-term sustainability of the project’s investment

(f) Improving of analysis, forecasting, planning, distribution, and management of the workforce through the HRIMS

(g) Establishment of distance learning, computer-based instruction, and virtual simulation education, which have been shown to be sustainable and cost-saving methods of training and engaging health care professionals to promote continuous medical education

(h) Building of complementarities across WBG projects and with other partners, to address constraints to the public and private sector.

59. **The project will also build the institutional capacity of public agencies to support HRH strengthening, distribution, and retention that is environmentally and socially sustainable.** The support to strategies, training of officials, investment in equipment, and M&E systems will improve the agencies' capacity to serve the public sector needs and help create value in the public health sector. The project will also strengthen the Government's ability to measure HRH investments' impact on quality-of-service delivery. Lastly, the project will promote gender equality in HRH development, reducing the skills gap in specialization and sub-specialty by breaking gender barriers and addressing the specific constraints related to woman.

60. **The 2023 budget foresees a smaller overall surplus of 0.9 percent of GDP**; however, social expenditures are scheduled to increase by 1.3 percentage points of GDP, reaching 7.9 percent of GDP, which bodes well for the financial sustainability of the project investments. This includes health spending increasing from 1.7 to 2.2 percent of GDP. Though small, the increase in health spending, coupled with the strong commitment to invest in HRH shown by the MoH and the GoA, provides reassurance to the sustainability of the project's investments. The 2023 budget targets a small overall fiscal surplus, based on an average oil price assumption of US$75 per barrel. This target may be surpassed if fuel prices remain close to the levels observed in early 2023. The primary balance surplus is expected to remain large in 2023, at 4.5 percent of GDP, but decline to about 4 percent in the medium term, still sufficient to maintain a downward trend of debt-to-GDP and comply with the non-oil primary balance rule under Angola's Fiscal Sustainability Law. Somewhat lower primary surpluses in the medium term and expected fiscal savings from fuel subsidy reform are expected to create additional fiscal space that can be used to sustainably fund higher spending on human capital investments, including health spending, while also maintaining a buffer to cope with any decline in oil prices, which might otherwise result in a fiscal deficit and increased financing needs.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

61. **A shortage of trained health care providers is a key stumbling block to improving health care workers' performance and providing services.** In Angola, many health providers lack the necessary curative and preventative skills to provide adequate health care. Thus, the Government spends US$4.3 million annually on medical evacuations to other countries and US$76 million on financing expatriate doctors. Therefore, the project will contribute to reducing the country's expenditure on medical evacuations and expatriate doctors. If the country achieves its goal of eliminating expat doctors by 2027, the project would have fully paid for itself soon after the project closure date, which speaks to the cost-efficiency of this operation. Further, the project will expand high-quality education for health care professionals, targeting roughly 96,000 beneficiaries (1 percent of the population employed in 2021). This will generate employment opportunities for health care professionals, associate health workers, subordinate/support staff, and other junior health workers. Additionally, the project will enhance female labor force participation and share of formal employment in total employment and boost health sector productivity with a spillover effect for the whole economy. More than 80.4 percent of employment in Angola is in the informal sector: 70.4 percent for men and 90.1 percent for women. However, in the health sector, informal employment is as low as 9 percent: 10.8 percent for men, and 7.2 percent for women. Therefore, the project will increase the participation of women in the labor market in a sector that provides high-quality jobs. Lastly, the project is expected to bring additional indirect health and economic

benefits to the general population from better health care services being delivered to the Angola population.

62. **Strengthening HRH can benefit Angola within and beyond the health sector.** The United Nations High-Level Commission on Health Employment and Economic Growth noted that enhanced investments in the health workforce could deliver a triple return of improved health outcomes, global health security, and economic growth.[8] Studies estimate an economic return of US$4 across lower-middle-income countries such as Angola for every US$1 invested in health.[9] Strengthening HRH will lead to improved quality of essential health services, which is critical for building human capital and increasing labor productivity. Productivity gains can result from (a) less time lost to an illness that would have otherwise been utilized in some economic activity, (b) less time spent in caring for sick family members, (d) allocation of resources to other economic activities, and (d) better learning outcomes of children who will eventually join the labor force. In addition, by investing in HRH at the national, provincial, and municipal levels, the project can have a spillover effect of preventing young people from leaving underserved regions to look for better opportunities for higher education in the capital, as is common right now. Over the last five years, the Government has invested heavily in building and rehabilitating hospitals, as highly skilled health workers are scarce in the country, and has also invested heavily and quickly in expanding high-quality education for health professionals, which will increase the return on the investment already made in physical infrastructure development.

63. **All direct and indirect costs of the project were considered.** Besides the costs associated with the project (Components 1 to 3), the costs associated with management, hiring of consultants, and M&E were considered a component of the project cost. An amount of US$10 million (5 percent of the loan) is projected to be allocated to program management and M&E (Component 3). Also, the MoH's cost in administering the loan can be an indirect project cost.

B. Fiduciary

(i) Financial Management

64. **An FM assessment was carried out to evaluate the adequacy of the project's FM arrangements** in accordance with the World Bank Guidance - Financial Management Manual for World Bank Investments Project Financing Operations, issued on September 7, 2021 (OPS5.05-GUID.180). The objective of this assessment was to determine whether the UCC, the implementing unit at the MoH, has acceptable FM arrangements for implementation of the project.

65. **The FM risk is assessed as Substantial.** The Substantial risk rating is due to the high inherent risk at the country level and complexity of the project, which entails activities implemented in all the 18 provinces of the country. In addition, the increased volume of work resulting from activities under the new project will lead to a work overload for existing staff and may consequently cause delays in generating the required periodic financial statements. The use of United Nations agencies in implementing certain activities may also cause delays in the completion of financial documentation of advances, leading to a risk of the project not closing as scheduled. The following FM actions are proposed to ensure the continued adequacy of the UCC's FM arrangements: (a) recruit a qualified and experienced project accountant and one FM assistant; (b) recruit an internal auditor; (c) update and adopt the PIM to include controls over activities in the new project; (d) update and program the computerized accounting software to facilitate the generation of required periodic financial statements; and (e) no later than six months after

project effectiveness recruit the external auditors. The FM arrangements in the UCC meet the minimum requirements for implementing World Bank-financed operations.

(ii) Procurement

66. **General considerations.** Procurement under the project will be carried out in accordance with the World Banks's Procurement Regulations for IPF Borrowers for Goods, Works, Non-Consulting and Consulting Services, dated November 2020. The project will be subject to the World Banks's Anticorruption Guidelines, dated October 15, 2006, revised in January 2011, and as of July 1, 2016. The project will use the STEP tool to plan, record, and track procurement transactions.

67. **PPSD.** The Procurement Unit of the MoH-UCC prepared a PPSD. This strategy has been reviewed by the World Bank, and the document (available as a separate project file) has been agreed with the World Bank. The PPSD presents details on how procurement activities will support the development objective of the project and deliver the best value for money under a risk-based approach. In addition, the PPSD includes the rationale for specific procurement decisions including the selection of the approach to market and procurement methods. One of the results of the PPSD is the Procurement Plan covering the first 18 months of the project (Annex to the PIM).

68. **Procurement Plan.** The Procurement Plan for the project has been developed with 27 packages: goods (4), non-consulting services (12), works (1), and consulting services (10). The detailed Procurement Plan is available as a separate project document, which will be updated annually or as needed to reflect the status of the implementation of each package or to add new packages as needed.

69. **The procurement risk is rated Substantial.** Major risks associated with the implementation of the project procurement activities are related to the MoH's capacity to comply with the World Bank's fiduciary requirements, prepare a realistic Procurement plan, and adequately use STEP. On the other hand, even though the MoH is experienced in the implementation of World Bank-funded projects, the actual health portfolio of projects does not have a senior procurement specialist based in Luanda. In view of the growing intervention of the World Bank's operations, it is necessary to continue having a full-time senior procurement specialist based in Luanda. A procurement assistant shall also be recruited to be exclusively dedicated to the project. In addition, other risks related to the capacity to prepare TORs; a lengthy internal procurement reviewing process; long periods to evaluate proposals by the evaluation committees; inadequate contract management, and governance risks associated with conflict of interest, fraud, and corruption, among others, are detailed in Annex 1, as well as in the mitigation measures. These risks should be closely monitored as they can adversely affect project implementation. The risk assessment will continue to be caried out during project implementation and adapted accordingly.

C. Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

D. Environmental and Social

70. **The environmental and social risk is currently rated Moderate.** This rating results from the combination of the following factors: (a) the project's focus on human resources development and financing activities, which pose low to moderate potential adverse environmental risks and impacts; (b) the expectation that the project activities will not be implemented in sensitive areas (this criterion will be considered in the exclusion list included in the PIM); (c) the UCC's relevant technical capacity to assess and manage the anticipated adverse risks and impacts in a manner consistent with the ESF objectives; and (d) the absence of relevant contextual factors that can exacerbate those risks and impacts. The project's potential adverse environmental risks and impacts will be mainly associated with: (a) the small-scale civil works planned to renovate the existing facilities of the old NSPH (now, integral part of the IES) and (b) the management of the e-waste generated by the decommissioning of the IT equipment acquired by the project to supply all training facilities. The refurbishment of the NSPH is anticipated to generate some adverse environmental and social risks and impacts, including: (a) soil and water resources pollution due to accidental spillages of hazardous products; (b) dust and noise emissions causing disturbance to sensitive receptors located in the vicinity of the NSPH; (c) generation of hazardous and non-hazardous waste, including demolition waste with asbestos; (d) occupational health and safety risks, including sexual exploitation and abuse and sexual harassment (SEA/SH); and (e) community health and safety (mainly related to construction-induced road traffic hazards). These risks and impacts are expected to be primarily site-specific (focusing on the areas affected by civil works), temporary, reversible, and manageable through cost-effective mitigation measures, which will be included in a site-specific Environmental and Social Management Plan. Digital-related activities to be financed and the decommissioning of the IT equipment acquired by the project are expected to generate e-waste that will be managed by implementing adequate e-waste management plans. The main social risks anticipated relate to possible inequities in access to benefits and activities supported by the project, including access to training and capacity-building opportunities. In addition, there is a need for stakeholder engagement, both at the national level associated with the overall program and at the provincial/local level relating to the benefits and value of the program. Another potential risk may be related to the levels of digital literacy among the rural target groups and potential exclusion of rural areas from project benefits.

71. **The risk of SEA/SH for this project is rated Substantial.** This is based on the country context; the health sector systems strengthening activities anticipated by the project; and the potential downstream risks regarding policies and mechanisms developed at the central, provincial, and municipal levels to address gender gaps in the health care work force. Additionally, it takes into consideration the need to create gender-friendly work environments, especially for female personnel, and reinforce health sector training and monitoring programs to address gender bias in health care and ensure appropriate instruction on GBV and SEA/SH risks for beneficiaries and health care workers. In Angola, drivers of risk include high rates of GBV, child marriage, child labor, child trafficking, general social acceptability of GBV, and insufficient enforcement of legislation on domestic violence and sexual harassment. Over one-third of women ages 15–49 (32 percent) have experienced physical violence since the age of 15 and 22 percent

in the last 12 months. Nearly eight percent of women ages 15–49 have experienced sexual violence their lifetime (being more common in urban than in rural areas), while five percent of women have experienced sexual violence in the last 12 months. Other drivers of risk linked with the activities anticipated by the project are as follows: (a) lack of a demonstrated track record by the MoH in implementing SEA/SH complaint mechanisms and addressing gender-based discrimination in the health sector; (b) lack of a code of conduct or behavioral standards that prohibit and sanction acts of SEA/SH by health care personnel; and (c) risk of producing a shift in gender dynamics due to increased engagement of women through revised human resources policies, which challenge established gender norms and increase SEA/SH risk. The PIU has adopted a programmatic approach for the management of SEA/SH risks for the health sector in Angola and developed a master SEA/SH Prevention, Mitigation, and Response Action Plan that covers the whole of the country health portfolio, including the World Bank-financed REDISSE IV and COVID-19 additional financing projects. This action plan is relevant for this new project and will be reviewed and adapted accordingly, ensuring implementation of codes of conduct, an accountability and response framework with grievance mechanism and service mapping, and a training and sensitization plan for project personnel and communities. In addition, the PIU has recruited a GBV specialist to oversee and manage the implementation of this master action plan.

V. GRIEVANCE REDRESS SERVICES

72. **Grievance redress.** Communities and individuals who believe that they are adversely affected by a project supported by the World Bank may submit complaints to existing project-level grievance mechanisms or the Bank'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 Bank's independent Accountability Mechanism (AM). The AM houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of Bank non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted to the AM at any time after concerns have been brought directly to the attention of Bank Management and after Management has been given an opportunity to respond. For information on how to submit complaints to the Bank's Grievance Redress Service (GRS), please visit http://www.worldbank.org/GRS. For information on how to submit complaints to the Bank's Accountability Mechanism, please visit https://accountability.worldbank.org.

VI. KEY RISKS

73. **The overall project risk is rated Moderate.** Most of the risks for this operation are rated Moderate: the macroeconomic, political, and governance risks, sector policies, and technical design. Further the environment and social risks are rated Moderate based on the nature of the activities included in this project and the capacity at the health PIU. The risk associated with personal data protection is also rated Moderate and will require a close follow-up by the World Bank in line with the aspects mentioned under the data protections section. The institutional capacity for implementation and sustainability, fiduciary, and SEA/SH risks are rated Substantial, which will require close monitoring and implementation support from the World Bank.

74. **Institutional capacity for implementation and sustainability is Substantial.** While the recent strengthening of the UCC in Angola has led to improved performance ratings of this coordinating unit in

implementing the three World Bank health sector-financed projects, the lack of qualified HRH and limited capacity of national sectoral agencies and provincial health departments causes the institutional capacity for implementation risk to be considered Substantial. Mitigation measures include the strong technical assistance support for policy development and institutional strengthening under Components 1 and 2 of this project. Sustainability risk is also rated Substantial, as the GoA and MoH will need to ensure that the national network of post-graduate training facilities the project will support establishing will be sustained after the project has ended. Mitigation measures for this risk will focus on the strong support under Component 1 for strengthening the governance capacity of the health workforce; strengthening HRH regulatory capacity; optimizing the utilization, retention, and performance of the available health workforce through HRIMS; and embedding cross-sectoral priorities in collaboration with Ministry of Higher Education. Additionally, the estimated annual US$6 million cost savings to the national state budget by eliminating expatriate doctors will create a fiscal space to further invest in further strengthening, expanding, and sustaining this network of post-graduate and in-service training facilities.

75. **Fiduciary risk is rated Substantial as described earlier.** The substantial FM risk rating is due to the high inherent risk at the country level as and complexity of the project that entails activities implemented in all the 18 provinces of the country. In addition, the increased volume of work resulting from activities under the new project will lead to a work overload for existing staff and may consequently cause delays in generating the required periodic financial statements. The substantial procurement risks are related to the capacity of the MoH to comply with the World Bank's fiduciary requirements, prepare a realistic procurement plan, and adequately use STEP. On the other hand, even though the MoH has experience in the implementation of World Bank-funded projects, the actual health portfolio of projects does not have a senior procurement specialist based in Luanda. Appropriate mitigation measures include expanding the fiduciary capacity within PIU by hiring FM and procurement assistants, auditors and providing on the ground capacity building to the hired staff. Further mitigation measures are outlined in annex 1: Implementation Support Plan.

76. **SEA/SH risk, categorized under 'Other risk', is rated Substantial.** This risk rating is linked with the activities anticipated by the project as follows: (a) lack of a demonstrated track record by the MoH in implementing SEA/SH complaint mechanisms and addressing gender-based discrimination in the health sector; (b) lack of a code of conduct or behavioral standards that prohibit and sanction acts of SEA/SH by health care personnel; and (c) risk of producing a shift in gender dynamics due to increased engagement of women through revised human resources policies, which challenge established gender norms and increase SEA/SH risk. To mitigate these risks, the PIU has adopted a programmatic approach which will be expanded for the management of SEA/SH risks for the health sector in Angola, including the revision and implementation of the SEA/SH Prevention, Mitigation, and Response Action Plan to ensure the implementation of codes of conduct, an accountability and response framework with grievance redress mechanism and service mapping, and a training and sensitization plan for project personnel and communities. In addition, the PIU has recruited a GBV specialist to oversee and manage the implementation of this master Action Plan, which will be leveraged for the implementation of this project.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: Angola
Human Resources capacity for Universal Health Coverage in Angola

Project Development Objectives(s)

The Project Development Objectives is to Improve the capacity and availability of Human Resources for Health in Angola.

Project Development Objective Indicators

Indicator Name	PBC	Baseline	Intermediate Targets	End Target
			1	
Improve capacity and availability of Human Resources for Health in Angola				
Increase in the number of health care workers with certified post-graduate level training from accredited facilities (Number)		0.00	13,000.00	29,000.00
Number of women health care workers with certified post-graduate level training (Number)		0.00	6,000.00	12,000.00
Improved density of doctors and nurses with post-graduate/specialized training (Number)		0.20	0.50	1.00
Percentage of health professionals absorbed in public healthcare facilities after completing post-graduate training with project support (Percentage)		0.00	60.00	90.00

Intermediate Results Indicators by Components

Indicator Name	PBC	Baseline	Intermediate Targets	End Target
			1	
HRH Governance, Policy, Curricula, and Information Systems				
HRH Development Plan developed with accompanying costed annual action plans and approved by government (Yes/No)		No	Yes	Yes
Accreditation system developed for the various pathways of medical and nursing post-graduation (Yes/No)		No	Yes	Yes
Percentage of healthcare workers registered in the HRIMS in all 18 provinces (Percentage)		0.00	50.00	90.00
Percentage of women healthcare workers registered in the HRIMS in all 18 provinces (Percentage)		0.00	20.00	40.00
Percentage of provinces generating 6-monthly reports from HRIMS (Percentage)		0.00	50.00	80.00
Training and Capacity Building of HRH				
Number of Centers of Reference equipped and offering in-person and distance learning post-graduate and in-service training (Number)		0.00	4.00	7.00
Number of satellite training facilities equipped and offering in-person and distance learning post-graduate and in-service training (Number)		0.00	14.00	27.00
Number of qualified mentors and supervisors in Centers of Reference to train and mentor junior staff (Number)		0.00	75.00	150.00
Number of women qualified mentors and supervisors in Centers of Reference to train and mentor junior staff (Number)		0.00	25.00	50.00
Number of administrative and hospital support staff receiving in-service training (Number)		0.00	4,000.00	9,000.00
Number of grants/scholarships provided for post-		0.00	1,500.00	3,000.00

Indicator Name	PBC	Baseline	Intermediate Targets	End Target
			1	
graduate training abroad in internationally accredited universities (Number)				
School of Public Health (as part of the Institute of Specialization in Health) rehabilitated and equipped with the support of the project (Yes/No)		No	No	Yes
Increase in the Number Masters / PhD programs being offered at NSPH (as part of the Institute of Specialization in Health) (Number)		0.00	3.00	5.00
Number of provinces that have established provider to provider telemedicine (Number)		0.00	3.00	7.00
Number of specialist consultations in country per year (Number)		250,000.00	300,000.00	350,000.00
Project Management, Monitoring and Evaluation				
Functional Steering Committee with inclusion of all health professional associations and health departments at national and provincial levels (Yes/No)		No	Yes	Yes
Number of external audits of the quality of training programs (Number)		0.00	2.00	5.00
Number of Provinces that have conducted assessments to identify entrenched gender gaps for HRH strengthening and developed the inclusion of remedial activities in the HRH Development Plan (Number)		0.00	9.00	18.00
Percentage of grievances that received a response through the GRM (Percentage)		0.00	80.00	100.00
Patient satisfaction rates (Percentage)		0.00	45.00	60.00
Postgraduate training satisfaction rates (Percentage)		0.00	50.00	70.00

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
Increase in the number of health care workers with certified post-graduate level training from accredited facilities	Increase in health care workers with certified post-graduate level training (number, disaggregated by province, rural Vs urban, gender and professional category).	Annually	Institute of Specializatio n in Health	Institute of Specialization in Health to collect date from the Reference Centers	MoH
Number of women health care workers with certified post-graduate level training	Number of women health care workers with certified post-graduate level training	Annually	Institute of Specializatio n in Health	Institute of Specialization in Health to collect data from Reference Centers	MoH
Improved density of doctors and nurses with post-graduate/specialized training	Improved density of doctors and nurses with postgraduate/specialized training. Ratio of doctors and nurses with post-graduate/specialized training per 10,000 population, disaggregated by province, urban Vs rural, gender and professional category	Annually	Institute of Specializatio n in Health and National Directorate for Human Resources for Health	Institute of Specialization in Health to consult the National Directorate for Human Resources for Health and Provincials departments for the required data	MoH
Percentage of health professionals absorbed in public healthcare facilities after completing post-graduate training with project support	Percentage of health professionals absorbed in public healthcare facilities after completing post-	Annually	National Directorate for Human Resources for	National Directorate for Human Resources for Health to collect date from National health	MoH

	graduate training with project support (percentage, disaggregated by province, urban Vs rural, gender and professional category). Numerator - number of health professionals absorbed in public healthcare facilities after completing post-graduate training with project support. Denominator - number of health professionals completing post-graduate training with project support.		Health	facilities	

Monitoring & Evaluation Plan: Intermediate Results Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
HRH Development Plan developed with accompanying costed annual action plans and approved by government	HRH Development Plan developed with accompanying costed annual action plans and approved by government	Annually	MoH	Assess whether Plan developed and approved	MoH
Accreditation system developed for the various pathways of medical and nursing post-graduation	Accreditation system developed for the various pathways of medical and nursing post-graduation	Annually	MoH	Assess whether the accreditation process has been developed	MoH

Percentage of healthcare workers registered in the HRIMS in all 18 provinces	Percentage of healthcare workers registered in the HRIMS in all 18 provinces (disaggregated by province, gender, professional categories, and specialization).	Every 6 months	MoH, HR Informati on Management System	HRH Information System	MoH
Percentage of women healthcare workers registered in the HRIMS in all 18 provinces	Percentage of women healthcare workers registered in the HRIMS in all 18 provinces	Every 6 months	Institute of Specializatio n in Health	Collection through the HRHIMS	MoH
Percentage of provinces generating 6-monthly reports from HRIMS	Percentage of provinces generating periodic reports from HRIMS	Every 6 months	MoH, HRIMS	HRIMS	MoH
Number of Centers of Reference equipped and offering in-person and distance learning post-graduate and in-service training	Number of Centers of Reference equipped and offering in-person and distance learning post-graduate and in-service training	Annually	MoH, Institut e of Specializatio n in Health	Assessment of Centers of Reference equipment and outputs	MoH
Number of satellite training facilities equipped and offering in-person and distance learning post-graduate and in-service training	Number of health training facilities equipped with digital e-learning platforms with the support of the project	Annually	MoH, Institut e of Specializatio n in Health	Assessment of the training facilities	MoH
Number of qualified mentors and supervisors in Centers of Reference to train and mentor junior staff	Number of qualified mentors and supervisors in Centers of Reference to train and mentor junior staff (disaggregated by Centers of Reference and Gender). Qualified as defined by	Annually	MoH, Institut e of Specializatio n in Health	Assessment of number of mentors and supervisors	MoH

	WHO minimum requirements and SOPs.				
Number of women qualified mentors and supervisors in Centers of Reference to train and mentor junior staff	Number of women qualified mentors and supervisors in Centers of Reference to train and mentor junior staff	Annually	Institute of Specialization in Health	Collecting data from the Centers of Reference	MoH
Number of administrative and hospital support staff receiving in-service training	Number of administrative and hospital support staff receiving in-service training (disaggregated by province, urban Vs rural, professional categories, and gender)	Annually	MoH, Institute of Specialization in Health	Assessment of Number of administrative and hospital support staff receiving professional development training	MoH
Number of grants/scholarships provided for post-graduate training abroad in internationally accredited universities	Number of grants/scholarships provided for post-graduate training abroad in internationally accredited universities (Number disaggregated by province, professional categories, specialties, and gender).	Annually	MoH, Institute of Specialization in Health	Institute of Specialization in Health to provide updated figures on scholarships provided	MoH
School of Public Health (as part of the Institute of Specialization in Health) rehabilitated and equipped with the support of the project	School of Public Health (as part of the Institute of Specialization in Health) rehabilitated and equipped with the support of the project	Annually	MoH	N/A	MoH
Increase in the Number Masters / PhD programs being offered at NSPH (as part of the Institute of Specialization in Health)	Number of Masters / PhD programs being offered at NSPH (as part of the Institute of Specialization in Health) after Project's support.	Annually	MoH	N/A	MoH

Number of provinces that have established provider to provider telemedicine	Number of provinces that have established provider to provider telemedicine	Annually	MoH	Collection of data from MoH Reference Centers	MoH
Number of specialist consultations in country per year	Number of specialist consultations in country per year (disaggregated by province, urban Vs rural)	Annually	MoH annual reports	MoH in collaboration with National Directorate for Hospitals	MoH
Functional Steering Committee with inclusion of all health professional associations and health departments at national and provincial levels	Functional Steering Committee with inclusion of all health professional associations and health departments at national and provincial levels (doctors, nurses, Diagnostic technicians, pharmacists)	Annually	MoH	N/A	MoH
Number of external audits of the quality of training programs	Number of external audits of the quality of training programs	Annually	MoH and external auditing agency	N/A	MoH
Number of Provinces that have conducted assessments to identify entrenched gender gaps for HRH strengthening and developed the inclusion of remedial activities in the HRH Development Plan	Number of Provinces that have conducted assessments to identify entrenched gender gaps for HRH strengthening and developed the inclusion of remedial activities in the HRH Development Plan	Annually	MoH	N/A	MoH
Percentage of grievances that received a response through the GRM	Percentage of grievances that received a response through the GRM	Annually	MoH	Collecting data from the National GRM system	MoH

Patient satisfaction rates	Patient satisfaction rates, measured by post-care satisfaction assessments in a random selection of health facilities at country level	Annually	MoH through national public healthcare network	Patient satisfaction evaluation assessments from a randomly selected sample of health facilities. Randomization process will be done at provincial level and data aggregated at provincial level. Final result of indicator will be a simple average of the provincial results.	MoH in collaboration with Provincial Directorates for Health
Postgraduate training satisfaction rates	Post-graduate training satisfaction rates, measured by the satisfaction of trainees after attending the training programs	Annually	Moh, Institute of Specializatio n in Health	All trainees will fill in a training program overall satisfaction form by the end of their training, Every year the simple average of these satisfaction form will be calculated.	MoH

ANNEX 1: Implementation Arrangements and Support Plan

COUNTRY: Angola
Human Resources Capacity for Universal Health Coverage in Angola

1. **The World Bank's implementation support will aim at assisting the MoH in achieving the project objectives and mitigating the project's technical, institutional, environmental social, and fiduciary risks.** The implementation support plan is tailored to the project needs and identifies the resources to be deployed by the World Bank. To ensure timely implementation and a regular flow of information, the team will hold regular meetings with counterparts at the project and component levels. These meetings will include discussions on fiduciary and environmental and social topics with the PIU, general project performance topics with the Directors at the MoH and Ministry of Finance, and separate technical meetings with the PIU and relevant counterparts. Capacity building will include training and awareness raising on social and environmental risk management, fiduciary aspects, and implementation support. Steps will also be taken to reduce dependency on international consultants in the PIU for project implementation as high consultant fees can distort the market and reduce budget availability for project activities. Furthermore, project interventions will be tailored to mainstream climate resilience and mitigation practices and women's ownership and control of assets through targeted activities.

2. **The implementation support team will include task team leaders (TTLs) and relevant specialists.** The team will conduct at least two implementation support missions per year, but the mission frequency may be increased as needed. In addition to regular implementation support missions, the team will provide implementation support taking advantage of the presence of key World Bank technical specialists in Angola, including financial and private sector, environmental and social, procurement, and FM specialists.

3. Project implementation support by the World Bank will cover the following aspects:

- **M&E of progress toward the PDO.** The TTLs will coordinate and oversee project implementation support, ensuring regular communication with the MoH, deployment of resources to address any project implementation challenges, and monitoring of the project's progress toward the PDO.
- **Technical.** Focusing on specific project components, technical experts will support implementation of activities, ensuring their alignment with the PDO and annual work plans. If needed, technical experts will provide inputs to the TOR for activities, review technical reports and other outputs, verify compliance with eligibility criteria, and support the MoH in ensuring that the M&E framework continuously meets project needs.
- **FM.** An FM specialist will assist the MoH in maintaining an FM system capable of accurately and timely reporting on the uses of project funds. It is expected that during the first year of project implementation, there will be four quarterly on-site visits to ascertain the adequacy of systems. The visits will be supplemented by desk reviews of the IFRs and audit reports. The FM supervision will adopt a risk-based approach, focusing on key risk areas such as the accuracy and reasonableness of budgets, their predictability and execution, compliance with

payment and fund disbursement arrangements, and the ability of the systems to generate reliable financial reports. Training will be provided to the project team as needed.

- **Procurement.** A procurement specialist will provide ongoing guidance and support to the MoH to ensure quality procurement. Support will include training and organization of procurement clinics to enhance the knowledge of the project's procurement team; review of procurement activities subject to the World Bank's prior review; and completion of post-procurement reviews, ensuring that recommendations of the reviews are implemented on time. The procurement specialist will conduct at least one on-site mission per year and at least 20 percent of contracts requiring post review will be subject to procurement post reviews and technical reviews.

- **Environmental and social.** One environmental specialist and one social specialist will provide regular support to the MoH on managing environmental and social risks and will join project implementation support missions, post review assessments, and site visits.

4. **Table 1.1 outlines the implementation support plan.** These requirements will be reviewed periodically to ensure that they meet project needs. Implementation support costs will be covered through the annual World Bank supervision budget to be managed by the TTLs.

Table 1.1. Project Implementation Support Plan

Timeline	Focus	Skills Required	Resource Estimate per Year
First 12 months	**Task management.** Project effectiveness and implementation launch, project compliance with legal covenants, establishment of project oversight structures and approval of the annual work plan, and first implementation mission	Health sector/HRH and digital experts	4 months
	Procurement. Guidance on Procurement Regulations, approval of the Procurement Plan in STEP, training of project procurement staff, and first review mission	Procurement specialist	1 month
	FM. Approval of project budget and initial disbursements, review of initial IFRs, review of FM procedures, training of project FM staff, and on-site visits	FM specialist	1 month
	Environmental and social. Support for the establishment of the Environmental and Social Management System and consistent application of policies and procedures, monitoring of the project's environmental and social risks, and proposal of further mitigation measures.	Environment specialist and social specialist	2 months
	Technical support. Technical advice on project activities and review technical specifications and TOR	Health sector/HRH and digital experts	3 months
13–72 months	**Task management.** Regular implementation support, monitoring of progress toward PDO, and suggestion for necessary adjustments, including through a midterm review	TTLs/health sector/HRH and digital experts	3 months
	Procurement. Regular procurement support and post-procurement reviews	Procurement specialist	1 month
	FM. Regular support, review of budgets, IFRs, and audit reports	FM specialist	0.5 months

Timeline	Focus	Skills Required	Resource Estimate per Year
	Environmental and social. Regular support to application of policies and procedures and application of the Stakeholder Engagement Plan and citizen engagement	Environment specialist and social specialist	1 month
	Technical support. Technical advice on project activities and review technical specifications and TOR	TTLs/health sector/HRH and digital experts	3 months

FM Arrangements

5. The FM risk is assessed as Substantial as mentioned in the main PAD, below a detailed description of the FM risks, the mitigation measures and the residual risk.

Table 1.2. FM Arrangements

Risk	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Yes/No)	Residual Risk
Inherent risk	**—**	**—**	**S**
Country level. The PFM system has weaknesses in budget execution, internal controls, and general external oversight.	The Government is committed to implementing PFM reforms to improve governance in public institutions. Development partners including the World Bank continue to support governance and institutional capacity building.	No	H
Entity level. The UCC is handling several projects, which may result in an increased workload and lead to delays in producing FM reports.	The UCC has experience handling World Bank-financed operations. Additional FM staff will be hired to help manage the increased workload. The UCC PIM will be updated to include FM procedures for the new activities. It will outline the roles and responsibilities of the various stakeholders. Training sessions will also be provided for new staff.	No	M
Project level. The project design is complex as it involves several entities with activities planned in all 18 provinces, which may delay financial data collection, recording, and reporting.	The roles and responsibilities of various entities and financial information processing guidelines will be detailed in the PIM. Regular project implementation missions will be carried out to ensure sound execution of the project activities.	No	S
Control Risk	**—**	**—**	**S**

Risk	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Yes/No)	Residual Risk
Budgeting. The budgeting process (preparation, approval, and monitoring) covering many activities and entities may not be clearly defined. The project may fail to prepare a realistic annual budget and work plan.	The PIM will outline the budget preparation, approval, execution, and monitoring procedures. The IFR will include a budget execution analysis.	No	S
Accounting. Delay in recording financial transactions due to high volume project activities in dispersed locations and entities. Lack of clarity in the chart of accounts may lead to confusion and errors in recording project financial transactions in correct expenditure categories.	To facilitate the accurate reporting of activity expenditure, the accounting software will be upgraded and programmed to record and generate financial reports in the format agreed upon with the World Bank.	No	S
Internal control. Internal control systems may be unable to prevent and detect errors, irregularities, and inefficient use of project funds. Approval and authorization controls (including for procurement) are documented but compliance may be weak.	The PIM will be reviewed and updated to ensure that procedures for additional project activities are detailed. The UCC has already an internal auditor and shall produce an annual risk-based audit program. The quarterly internal audit report will be prepared and submitted to the World Bank.	No	S
Funds flow. Delays in preparing the necessary documentation to support disbursements and replenishment of fund accounts, causing cash flow constraints.	The UCC FM specialist, who is well experienced, will handle the project’s disbursements portfolio. In addition, the PIU will recruit a qualified accountant and treasury assistant to be dedicated to this project. A Designated Account (DA) in US dollars will be opened at a commercial bank acceptable to the World Bank, to make payments to local suppliers and other service providers. Another payment method, direct payment, and reimbursement will be available to facilitate payments. The project will make use of direct payment.	No	S
Financial reporting. IFRs produced by the UCC may not be submitted in a timely or may be inaccurate.	Use accounting software to generate the financial report of the project. Comments provided by the World Bank on the quarterly reports will help improve the quality.	No	M

Risk	Risk Mitigating Measures Incorporated into Project Design	Conditions for Effectiveness (Yes/No)	Residual Risk
Auditing. Audits reports are often delayed. The project may experience difficulties implementing audit recommendations. Management Letters are long-winded and identified issues are not quantified, making it difficult to ascertain if these are material enough to qualify the audit report.	An independent and qualified external audit firm will be hired to conduct the annual financial statement audit. The World Bank will monitor audit reports submission compliance and follow up on implementation of the recommendations.	No	M
Governance and accountability. The possibility of corrupt practices, including bribes, abuse of administrative and political positions, misprocurement and misuse of funds, and so on, are critical issues.	Robust FM arrangements (including a comprehensive annual audit of project accounts, World Bank FM supervision including review of transactions, and asset verification) are designed to mitigate the fiduciary risks in addition to UCCs' overall internal control systems. The UCC has procurement specialists in place and the recruitment of FM staff will mitigate these risks.	No	S
OVERALL FM RISK	—	—	**S**

Note: H = High; S = Substantial; M = Moderate.

Table 1. 3. FM Action Plan

No.	Action	Responsible Entity	Completion Date
1	Recruit a project FM assistant	UCC	By project effectiveness
2	Update and adopt the PIM	UCC	By project effectiveness
3	Updated and customized the accounting software for the project	UCC	Within three months of effectiveness
4	Recruit an accountant	UCC	Within three months the effectiveness
5	Recruit an external auditor	UCC	No later than six months after the effectiveness

6. **Budgeting.** The UCC and MoH will prepare the annual work, budget, and Procurement Plans. The yearly work plan should contain objectives, expected outcomes, and performance indicators. The UCC will also produce variance analysis reports comparing planned and actual expenditures every quarter. The periodic variance analysis will enable the timely identification of deviations from the budget. These quarterly variance analysis reports will be part of the unaudited IFRs submitted to the World Bank. The budget preparation and monitoring of budget execution are described in the existing Financial Procedures Manual, and formats for annual budget and monitoring reports are included as annexes.

7. **Staffing.** The UCC will be responsible for the fiduciary aspects of the project. The UCC has already appointed an FM specialist with relevant experience to perform his/her duties and obligations on the current health portfolio and will recruit a qualified accountant and treasury assistant to be dedicated to

this project. The overall responsibility of project FM matters rests with the UCC FM specialist reporting to the coordinator. The TOR of the fiduciary staff and recruitment process will be agreed upon with the World Bank.

8. **Accounting.** Using the existing accounting software, the UCC will account for the project's funds, expenditures, and resources. The basis of accounting will be Financial Reporting on Cash Basis. This accounting software should be capable of facilitating the maintenance of records of the project's financial-related activities and producing reliable financial reports required to monitor and manage project implementation progress effectively. The accounting software will be updated and customized within three months after effectiveness.

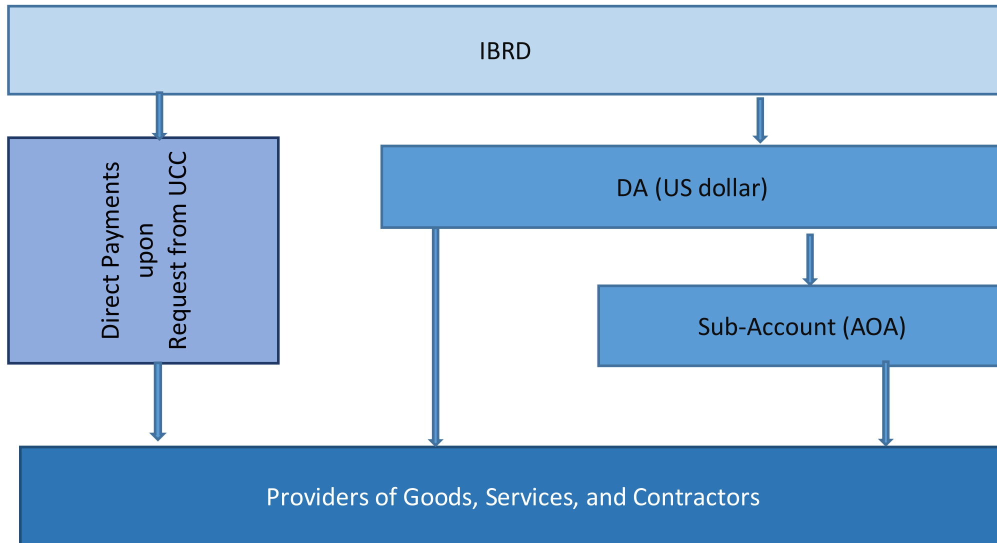
9. **Internal control.** The FM procedures should include institutional arrangements, budget and budgetary control, disbursement procedures and banking arrangements, receipt of goods and payment of invoices, internal control procedures, accounting system, transaction records, reporting requirements, and audit arrangements. Administrative and internal control processes will be documented in the Finance and Managerial Procedures Manual that will be integrated into the PIM. This manual should be revised and adopted before project effectiveness.

10. **Internal audit.** The General Inspectorate 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 General Inspectorate of Finance has limited capacity (in terms of the number and skills of its staff), and therefore, the project may not benefit from its review of this operation. The UCC will recruit an internal auditor, who will review the internal control systems in place and provide quarterly reports, no later than three months after effectiveness. The risk-based annual audit program and audit reports will be submitted to the World Bank for review and comments.

11. **Financial reporting.** The UCC will prepare quarterly unaudited IFRs. The IFRs will be submitted to the World Bank 45 days after the end of each quarter. The format and content of the IFRs have been agreed between the World Bank and the implementing agency. The IFRs will include the following: (a) a narrative on progress achieved during the period on activities implementation, to provide context for financial information analysis; (b) a sources and uses of funds statement, presenting the situation of the period and the cumulative one since the beginning of the project; (c) a statement of the use of funds by components, for the reporting period and cumulatively; (d) reconciliation of DAs; (e) the annual budget analysis on accrual compared to forecast; (f) the situation of unjustified advances and relevant explanation; and (g) the situation of United Nations agencies' advances documentation based on the financial report received.

12. **Flow of funds and disbursement arrangements.** To facilitate implementation of the project activities, the UCC will establish and maintain one segregated DA for the deposit of IBRD funds in US dollars. Funds in the DA will be used to finance eligible project expenditures in accordance with the Financing Agreement and the Disbursement and Financial Information Letter (DFIL). Disbursing the funds through direct payments, reimbursement, and particular commitments disbursement methods will also be available. Details are included in the DFIL. From the DA, the UCC will: (a) make payments for foreign consultants and suppliers of goods and services and (b) transfer funds to the DA sub-account in local currency to facilitate payments of local eligible project expenditures. Figure 1.1 depicts the fund's flow mechanism for the project activities to be financed under the traditional disbursement methods.

Figure 1.1. Flow of Funds Mechanism



13. **Auditing.** The annual project financial statements will be audited, by an independent audit firm, selected on the basis of TOR agreed with the World Bank, in accordance with International Standards on Auditing. The audit scope will include entities managing sub-accounts and activities in decentralized locations. The audit report together with the 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.

14. **Effectiveness condition**. Hiring a FM assistant prior to project effectiveness.

15. **Dated covenants.** Within three months after the project's effective day, the UCC should (a) recruit an accountant, , (d) update and customize the computerized accounting software, and (e) no later than six months after project effectiveness recruit the external auditors.

16. **Implementation support plan.** FM implementation support missions will take place at least twice per year, other FM support will include reviews of IFRs, internal audit reports, audited financial statements, and the internal control systems and governance arrangements described in this assessment. Training and guidance will also be provided to the implementing teams.

Procurement Arrangements

17. **Applicable procedures.** Procurement of input-based (procurable) items under the project will be carried out in accordance with the World Bank's 'Procurement Regulations for IPF Borrowers' (Procurement Regulations), dated November 2020, and as amended over time. Moreover, the project will be subject to 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 on July 1, 2016, and other provisions stipulated in the Financing Agreement.

18. **Assessment of national procedures.** The Angola Procurement Law No 41/20 was approved on December 23, 2020. Despite recent improvements, the World Bank decided that the Angola Procurement Law will not apply for procurement under this project. Therefore, the World Bank's Procurement Regulations will apply for all procurement under this Project.

19. **Procurement arrangements and institutional capacity.** The MoH will be the primary implementing agency for this project. The UCC leads the implementation of World Bank-financed health sector investments in Angola and will be responsible for project management and fiduciary functions for the project. The UCC is staffed and experienced in managing World Bank-financed projects. The UCC is led by an operations manager and supported by technical, fiduciary, and administrative staff overseeing the operations related to the HSPSP, the GAVI Additional Financing, the REDISSE IV Regional Project, and the COVID-19 operation. Even though the MoH is experienced in the implementation of World Bank-funded projects, the actual health portfolio of projects does not have a senior procurement specialist based in Luanda. In view of the growing intervention of the World Bank-financed operations, it is necessary to have a full-time senior procurement specialist based in Luanda. The capacity at the MoH and UCC will also be reinforced with the recruitment of a procurement officer to be dedicated to this project.

20. **Frequency of procurement reviews and supervision.** The World Bank's prior and post reviews will be carried out based on thresholds in line with project procurement risk. The World Bank will carry out implementation support missions every six months and annual post-procurement reviews; the standard post-procurement reviews by World Bank staff should cover at least 20 percent of contracts subject to post review. The World Bank may also conduct an independent procurement review at any time until two years after the closing date of the project.

21. **Training, workshops, and conferences.** Training (including training material and support), workshops, and conference attendance will be carried out based on an approved annual training and workshop/conference plans. A detailed plan providing the nature of training/workshop, number of trainees/participants, duration, staff months, timing, and estimated cost will be submitted to the World Bank for review and approval before initiating the process. The appropriate methods of selection will be derived from the detailed schedule. After the training, beneficiaries will be requested to submit a brief report indicating what skills have been acquired and how these skills will contribute to enhance his/her performance and contribute to the attainment of the project objective.

22. **Operational costs.** Operating costs financed by the project are incremental expenses, including office supplies, vehicles operation and maintenance, maintenance of equipment, communication costs, and supervision costs (that is, transport, accommodation and per diem). They will be procured using the procurement procedures specified in the Procedures Manual (administration, finance, and accounting).

23. **Procurement Manual.** Procurement arrangements, roles and responsibilities, methods, and requirements for carrying out procurement under the proposed project shall be elaborated in detail in the Procurement Manual, which will be a section of the PIM. The PIM shall be prepared by the borrower and agreed with the World Bank before project effectiveness.

24. **Procurement risks.** Major risks associated with the implementation of the project procurement activities are related to the capacity of the MoH to comply with the World Bank's fiduciary requirements, prepare a realistic Procurement Plan, and adequately use STEP. Overall, the procurement risks are as summarized in table 1.4.

Table 1.4. Procurement Risk Assessment and Mitigation Action Plan

No.	Risk Description	Description of Mitigation	Risk Owner	Time Frame
1	Potential procurement delays: experience with the	• Careful and prompt procurement planning based on a dynamic market	MoH	During implementation

No.	Risk Description	Description of Mitigation	Risk Owner	Time Frame
	past and ongoing projects in health sector show frequent procurement delays due poor procurement planning and lack of appropriate market analysis.	analysis and realistic scheduling advanced preparation of technical specifications or TORs. • Periodic review of scope and cost estimation for alignment with project coordination.		
2	Lengthy internal procurement reviewing process that may cause implementation delays.	• Prepare and adopt a Project Implementation Manual including a volume on procurement comprising of clear rules, step by step procedures and responsibilities, timeline requirements for procurement activities, actions and decisions, sample documents and evaluation report for small procurements, and so on. • Adopt operation procedures for project implementation with step-by-step procedures, responsibilities, and timelines requirements for procurement activities, actions, and decisions.	MoH	During implementation
3	Stretched period to evaluation proposals by the evaluation committees may cause project implementation delays	• Ensure that the evaluation committee members are invited upfront and have time allocated and appropriate experience/skills in carrying out evaluation processes. • Assign a procurement practitioner to present the criteria and the basic rules of evaluation and document the results in the moment.	MoH	During implementation
4	Inadequate contract management and lower-than-required quality of procured solutions	• Emphasis and training on appropriate contract management, regular physical inspections by the World Bank supervision mission	MoH	During implementation
5	Governance risks associated with conflict of interest, fraud, and corruption, which may adversely affect the efficiency and effectiveness of the project implementation	• Enhanced disclosure of procurement information, including publication of the annual Procurement Plan and a quarterly summary of the contract award information for all procurement packages on project website and '*Jornal de Angola'* (national newspaper). • Establish a procurement complaint handling mechanism consistent with the Government Procurement Rules and World Bank requirements.	MoH	During implementation

No.	Risk Description	Description of Mitigation	Risk Owner	Time Frame
		• Require staff involved in procurement to declare their interest and sign a declaration form. • Monitoring and reporting on implementation of actions for strengthening transparency and procurement training for the project.		
6	Limited competition by individual consultants	• Ensure advertisement locally (newspapers, Jobartis platform, and others) and internationally (STEP/United Nations Development Business), and proactively identify potential consultants (get references/long lists from the World Bank or contact other Lusophone countries, among other initiatives)	MoH	During implementation
7	Cost increase	• Use price revision even if contract timeline is less than 18 months.	MoH	During implementation
8	Local currency fluctuations	• Project budgeted in hard currency and fluctuation of local currency will be minimum.	MoH	During implementation
9	Suppliers have difficulties in accessing funding, bank guarantees, and foreign currency and there are payment delays that may affect their performance	• Provide in bidding documents and contracts for payments in foreign currency, bank transfer instead of letters of credit, bid securing declarations instead of bank guarantees if practicable. The project should however not transfer all risks to itself (be careful with advance payments, require performance security as needed)	MoH	During implementation
10	Inaccuracy of scope/specification of IT systems	• Focus on prior approval process, use of expert knowledge, and investment in time on design requirements	MoH	During implementation
11	Delayed delivery on IT systems procurement (lack of interests, language barriers, and distrust in existing infrastructure to host such solutions)	• Advance planning with appropriate reservation for delays. Timely processing of procurement transactions.	MoH	During implementation
12	Ensuring an entity to manage grants, insurance, travel, and accommodation and overall liaison with grant beneficiaries.	• Stakeholder engagement to foster early identification of an entity with skills/experience/availability to manage large US dollar amounts in grants for up to 5,000 grant beneficiaries throughout the project implementation period.	MoH	During implementation