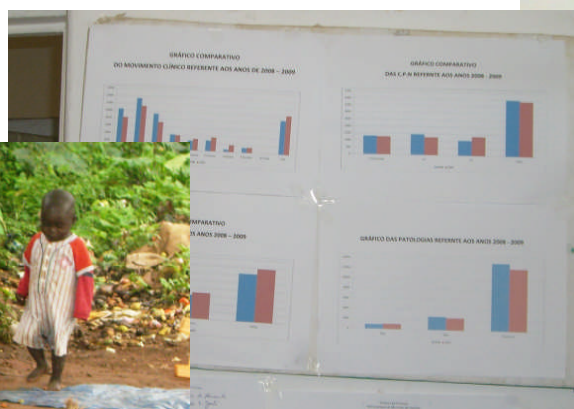


ANGOLA HEALTH SYSTEM ASSESSMENT 2010



MATERNIDADE



July 2010

This publication was produced for review by the United States Agency for International Development. It was prepared by Catherine Connor (Abt Associates Inc.), Denise Averbug (Abt Associates Inc.) and Maria Miralles (International Relief and Development) for the Health Systems 20/20 project.

Mission

The Health Systems 20/20 **cooperative agreement**, funded by the U.S. Agency for International Development (USAID) for the period 2006-2011, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

July 2010

For additional copies of this report, please email info@healthsystems2020.org or visit our website at www.healthsystems2020.org

Cooperative Agreement No.: GHS-A-00-06-00010-00

Submitted to: Robert Emrey, CTO
Health Systems Division
Office of Health, Infectious Disease and Nutrition
Bureau for Global Health
United States Agency for International Development

Recommended Citation: Connor, Catherine, Denise Averbug, and Maria Miralles. July 2010. *Angola Health System Assessment 2010*. Bethesda, MD: Health Systems 20/20, Abt Associates Inc.



Abt Associates Inc. | 4550 Montgomery Avenue | Suite 800 North
| Bethesda, Maryland 20814 | P: 301.347.5000 | F: 301.913.9061
| www.healthsystems2020.org | www.abtassociates.com

In collaboration with:

| Aga Khan Foundation | Bitrán y Asociados | BRAC University | Broad Branch Associates
| Deloitte Consulting, LLP | Forum One Communications | RTI International
| Training Resources Group | Tulane University School of Public Health and Tropical Medicine

ANGOLA HEALTH SYSTEM ASSESSMENT 2010

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government

ABSTRACT

The Health Systems 20/20 Project fielded a three-person team to conduct a rapid assessment of the Angolan health system to inform USAID/Angola's new health sector strategy for 2011-2015 and provide recommendations for the Angolan Ministry of Health (MINSA) that is launching a new district health strategy. This assessment updates a similar assessment done in 2005.

Since 2005, the Angolan health system has realized progress in health financing, human resources, information systems, governance, and service delivery, facilitated by continued peace, political stability, rapid economic growth, and major investments in infrastructure such as roads, water, and housing. Although prevalence of underweight children and fertility have declined significantly, key indicators such as infant and under-five mortality, maternal mortality and HIV prevalence appear stagnant are still high compared to regional averages. Health sector stakeholders are benefiting from the availability of new data from health surveys, studies, and slight improvements in the routine facility and epidemiological surveillance systems. Government health financing continues to be relatively low at 5 percent of total public expenditures, but is more equitable and effective as public spending on primary health care tripled. Access to health services rose slightly but is still less than half the population.

MINSA is demonstrating political commitment to improve access to health services and equity through its district health strategy, which has the explicit support of major partners such as the European Union, World Bank, and UN agencies. As implementation begins in earnest, the district health strategy crystallizes specific challenges facing MINSA and its partners: funding of non-labor recurrent costs, consistent supply of essential medical products, integration of vertical programs at the district level, how to extend access, how to reach communities, and donor coordination.

CONTENTS

Abstract.....	v
Acronyms.....	xiii
Acknowledgments.....	xvii
Executive Summary.....	xix
1. Background.....	1
2. Country Overview.....	3
2.1 General	3
2.2 Health	4
2.2.1 Health Status	4
2.2.2 Health System	6
3. Methodology	9
3.1 Framework for the Health Systems Assessment Approach.....	9
3.2 Phase 1: Document Review and Interviews.....	10
3.3 Phase 2: In-Country	10
4. Technical Modules.....	13
4.1 Governance.....	13
4.1.1 Overview	14
4.1.2 Decentralization and District Revitalization.....	16
4.1.3 Voice.....	17
4.1.4 Responsiveness	18
4.1.5 Technical Oversight	18
4.1.6 Service Delivery.....	19
4.1.7 Information, Reporting, and Advocacy.....	19
4.1.8 Directives, Oversight, and Resources.....	20
4.1.9 Donors and Donor Coordination	20
4.1.10 Summary	21
4.2 Health Financing	23
4.2.1 Overview	23
4.2.2 Resource Mobilization	24
4.2.3 Resource Pooling and Allocation	26
4.2.4 Purchasing.....	29
4.2.5 The Budgetary Process.....	30

4.2.6	Resource Flows and Management	31
4.2.7	Summary of Findings: Financing.....	36
4.3	Human Resources	37
4.3.1	Human Resources Data.....	38
4.3.2	Distribution of Health Care Professionals	40
4.3.3	Presence of a Human Resources Information System (WHO 2009).....	41
4.3.4	Human Resources Planning.....	42
4.3.5	Job Classification System and Job Descriptions.....	42
4.3.6	Compensation and Benefits.....	44
4.3.7	Hiring Process and Licensing Requirements	44
4.3.8	Health Worker Training and Supervision.....	45
4.3.9	Summary of Findings: Human Resources.....	46
4.4	Medical Products Management.....	47
4.4.1	Overview	47
4.4.2	Managing Selection	48
4.4.3	Procurement	49
4.4.4	Storage, Distribution, and Logistics	51
4.4.5	Rational Use	54
4.4.6	Summary of Findings: Medical Products.....	54
4.5	Health Information Systems	59
4.5.1	Overview	59
4.5.2	HIS Regulations and Policies	60
4.5.3	HIS Components	60
4.5.4	A Single Health Information System.....	64
4.5.5	Data Quality	65
4.5.6	Data Analysis and Use	65
4.5.7	Summary of Findings: Health Information System.....	66
4.6	Service Delivery.....	67
4.6.1	Organization of MINSA and Service Delivery.....	67
4.6.2	Health Facilities.....	70
4.6.3	Services Provided	72
4.6.4	Coverage.....	73
4.6.5	Productivity and Quality.....	74
4.6.6	Referral Systems	75
4.6.7	Role of the Private Sector.....	75
4.6.8	Summary of Findings in Service Delivery.....	78
5.	Summary of Findings and Opportunities.....	79
5.1	Financing of Non-Salary Recurrent Costs	79
5.2	Essential Medical Products.....	81
5.3	Addressing the Human Resources Issue	83

5.4 Integration of Services at the District Level	85
5.5 Reaching Communities and Households	86
5.6 Donor Coordination	88
5.7 Beyond the Health Sector.....	88
5.8 Promising Environment	90
Annex A: Indicator Table	91
Annex B: Donor Map of Programs in Angola Health Sector..	97
Annex C: Angola Health Systems Assessment Workshop ...	105
Annex D: Scope of Work.....	115
Annex E: Field Visit to Huambo Province (11–14 April, 2010).....	121
Annex F: Contact List.....	123
Annex G: Documents Consulted	127

LIST OF TABLES

Table 1: Selected Indicators for Angola and Sub-Saharan Africa Region.....	xx
Table 2: Summary of Findings, Recommendations, and Expected Results from 2005 Angola HSA	2
Table 3: Health Status Indicators	5
Table 4: Health Service Indicators	5
Table 5: Construction of Health Facilities in Five Provinces 1976– 1999 and 2000–2006.....	8
Table 6: What's New Since 2005 in Governance.....	14
Table 7: Angolan Political Structure and Public Health Service Delivery System by Level	15
Table 8: Key Policies, Legislations, and Strategic Plans.....	17
Table 9: Performance of Governance.....	22
Table 10: What's New Since 2005 in Health Financing.....	23
Table 11: Performance of Health Financing in Angola Compared to Sub-Saharan Africa.....	24
Table 12: Public Expenditures Total and Health 2001–2009	25
Table 13: Public Capital Investment in Health 2001–2005 in USD (millions) and Percentages.....	28
Table 14: Government Planning and Budgeting Calendar.....	30
Table 15: Execution of the Public Health Budget 2000–2005	34
Table 16: Performance of Health Financing in Terms of Health System Assessment Criteria	36
Table 17: What's New Since 2005 in Human Resources.....	37
Table 18: Health Workers in the Public Health Sector in Angola by Province	38

Table 19: Number of Districts by Province with Health-Worker-to-Population Ratios in Each Range	40
Table 20: Proportion of Health Workers in Key Categories in Five Provinces.....	41
Table 21: Performance of Human Resources for Health in Terms of the Health System Assessment Criteria	46
Table 22: What's New Since 2005 in Medical Products	47
Table 23: Value of Expenditures on Medicines 2005-2006 for Select Provinces.....	50
Table 24: Rational Use Indicators (MINSA/WHO 2007).....	54
Table 25: Availability of Essential Supplies in Health Units.....	55
Table 26: Availability of Essential Equipment in Health Units.....	55
Table 27: Summary of Medical Products Management in Terms of the Health Systems Performance Criteria.....	58
Table 28: What's New Since 2005 in Health Information Systems.....	59
Table 29: Performance of the Health Information System in Terms of the Health System Assessment Criteria.....	66
Table 30: What's New Since 2005 in Service Delivery	67
Table 30: Number of Health Facilities in Angola by Type from 2003-2009	71
Table 31: Services Provided and Population Coverage for Each Type of Health Facility According to REGUSAP	71
Table 32: Services Required and Provided at Three Facility Types in the Huambo Province	73
Table 33. Source of Health Services for Treatment of Childhood Illness	77
Table 34: Performance of the Service Delivery System in Terms of Health System Assessment Criteria	78

LIST OF FIGURES

Figure 1: Health Service Delivery Levels.....	7
Figure 2: The WHO Framework of the Six Health System Functions	9
Figure 3. Selected Governance Indicators for Angola and SSA.....	14
Figure 4. Public Health Operational and Investment Expenditures in USD (millions) by Level of Care, Administration, and Medical Education 2000-2005	27
Figure 5: Population (left axis) and Total Public Budget per Capita in USD (right axis) by Province for 2010	29
Figure 6: Structure of Budget Dependence Since 2008.....	31
Figure 7. Health System Resource Flows in 2005	32
Figure 9. Ratio of Health Workers in Angola in Comparison with Sub-Saharan Africa Regional Average.....	39
Figure 10: Flow of Medical Products in Angola.....	52
Figure 11. General Schema of the Public Routine Health Information System – Service Utilization and Surveillance Data	64
Figure 12. MINSA Organizational Chart.....	68

Figure 13. Summary of Administrative and Service Delivery Levels of
the Angolan Health System..... 70

ACRONYMS

ACT	Artemisinin-Based Combination Therapy
AFAPOS	Pharmacist Association in the Huambo Province
AIS	AIDS Indicator Survey
ANASO	Angolan Network of Organizations for AIDS Services
ANC	Antenatal Care Surveillance
BSS	Behavior Surveillance Studies
CACS	<i>Conselhos de Auscultação e Concertação Social</i> (Consultative Forums)
CCM	Country Coordination Mechanism
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
CONGA	Committee of NGOs in Angola
CPI	Corruption Perceptions Index
DHS	Demographic and Health Survey
DNME	<i>Direcção Nacional de Medicamentos e Equipamentos</i> (National Directorate of Medicines and Medical Supplies)
DNSP	Directorate of Public Health
DPS	<i>Direcção Provincial de Saúde</i> (Provincial Health Authority)
DPT	Vaccine Against Diphtheria, Pertussis (Whooping Cough) and Tetanus
EMOC	Emergency Obstetric Care
ENSA	National Insurance Company of Angola
EU	European Union
FIOCRUZ	Oswaldo Cruz Foundation (Brazil)
FONGA	Forum of Angolan NGOs
GOA	Government of Angola
GEPE	<i>Gabinete de Estudos, Planeamento e Estatística</i> (Department of Planning, Ministry of Health)
GF	Global Fund
HDR	Human Development Report
HIS	Health Information System(s)
HR	Human Resources
HSA	Health System Assessment

IBEP	<i>Inquérito sobre o Bem-Estar da População</i> (Household Wealth and Expenditure Survey)
ICC	Inter-Agency Coordination Committee
IMAI	Integrated Management of Adult Illnesses
IMCI	Integrated Management of Childhood Illnesses
INE	<i>Instituto Nacional de Estatística</i> (National Statistics Institute)
INN	International Nonproprietary Name
INLS	<i>Instituto Nacional de Luta Contra Sida</i> (National Institute for the Fight Against AIDS)
IPT	Intermittent Preventive Treatment
ITN	Insecticide-Treated Nets
KAP	Knowledge, Attitudes and Practices
LNCQ	Quality Control Laboratory
LUPP	Luanda Urban Poverty Program
MCH	Maternal and Child Health
MAPESS	Ministry of Public Administration
MICS	Multiple Indicator Cluster Survey
MINFIN	Ministry of Finance
MINPLAN	Ministry of Planning
MINSa	Ministry of Health
MIS	Malaria Indicator Survey
MPLA	<i>Movimento Popular de Libertação de Angola</i> (Popular Liberation Movement of Angola)
MSH	Management Sciences for Health
NEDP	National Essential Drugs Program
NEML	National Essential Medicines List
NGO	Non-governmental Organization
NHA	National Health Accounts
OD	<i>Orgão Dependente</i> (Dependent Budgetary Unit)
OGE	General State Budget
OOP	Out of Pocket (expenditures)
PASS	<i>Programa de Apoio ao Sector de Saúde</i> (Program to Support the Health Sector - EU Project)
PAV	Expanded Program on Vaccination
PDM	<i>Programa de Desenvolvimento Municipal</i> (District Development Project)

PEPFAR	US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLACE	Priority for Local AIDS Control Effort
PMI	President's Malaria Initiative
PMTCT	Preventing Mother-to-Child Transmission of HIV
PNS	Política Nacional de Saúde (National Health Policy)
PNME	National Essential Drugs Program
PTC	Hospital-based Pharmacy and Therapeutics Committees
RDFs	Revolving Drug Funds
REGUSAP	<i>Regulação do Sistema de Atendimento Primário</i> (National Health System Regulations)
RMS	<i>Repartição Municipal de Saúde</i> (Municipal Health Department)
SES	<i>Serviços Essenciais de Saúde</i> (USAID's Essential Services Project)
SIGFE	<i>Sistema Integrado de Gestão das Finanças do Estado</i> (National Financial Management System)
SIS	<i>Sistema de Informação Sanitária</i> (Health Information System)
SOWC	State of the World's Children (UNICEF)
SSA	Sub-Saharan Africa
TBA	Traditional Birth Attendant
UMC	Uppsala Monitoring Center
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session (UNGASS)
UNICEF	United Nations Children's Fund
UNITA	<i>União Nacional para a Independência Total de Angola</i> (National Union for the Total Independence of Angola)
UO	<i>Unidade Orçamental</i> (Budgetary Unit)
US	<i>Unidade Sanitária</i> (Health Unit)
USAID	United States Agency for International Development
USG	United States Government
WDI	World Development Indicators
WHO	World Health Organization
WHOSIS	World Health Organization Statistical Information System

ACKNOWLEDGMENTS

This assessment was funded by USAID/Angola. The team is enormously indebted to Bart Bruins, Gisele Guimaraes, and Domingas Canhanga at USAID/Angola for their extensive support and involvement in every step of the assessment process. The team is very grateful to His Excellency, Dr. José Van Dúnem, Minister of Health; government officials, facility staff, representatives of donor and UN agencies, and civil society organizations who shared their time and insights during interviews, meetings, and the stakeholder workshop. A special thanks to Dra. Helga Freitas of MINSA for her guidance and contributions on a Sunday when she worked with the team to prepare for the stakeholder workshop.

The first draft of the report benefitted greatly from comments from Mary Ann Abeyta-Behnke and Toni Boni of USAID and Bernard Couttelenc, health economist from Brazil. The final report improved significantly after review and detailed comments from Bart Bruins, Dr. Koen Vanormelingen of UNICEF, and Gisele Guimaraes. Copyediting was done by Beatrice M. Spadacini and formatting by Jan Nicholson.

EXECUTIVE SUMMARY

In 2005 the Partners for Health Reform*plus* project (PHR*plus*) – the predecessor to the Health Systems 20/20 project (HS 20/20) – conducted a Health System Assessment (HSA) in Angola to inform USAID/Angola's health sector programming. The HSA identified the relative strengths and weaknesses of the country's health system and provided recommendations for improvement. Since then, USAID has implemented a number of health projects in areas such as malaria, HIV/AIDS, family planning, and maternal and child health. Other donors such as UNICEF, the World Health Organization (WHO), the World Bank and the European Union (EU) have also carried out major activities in Angola with the Ministry of Health (MINSA). Five years later, Angola's development of a new district health strategy coincides with the USG/Angola internal process for a new five year health sector strategy.

This assessment methodology is based on the Health Systems Assessment Approach, a rapid indicator-based process developed by USAID/GH/HIDN. The approach covers the six core health systems components: governance/stewardship, financing, service delivery, human resources, pharmaceuticals, and health information systems.

PHASE I (February – March 2010): This phase was conducted in Washington DC. The team reviewed various documents and reports including but not limited to: the 2005 Angola HSA, health project reports and surveys, and population reports, and strategy documents. The team consulted USG staff in Angola and Washington who backstop Angola programs such as HIV/AIDS, malaria (The President's Malaria Initiative - PMI), Reproductive Health (RH), Tuberculosis (TB), water and sanitation, democracy and governance. The HSA team coordinated with USG/Angola to select and contact the key informants to be interviewed, draft the field schedule, and set up appointments.

PHASE 2 (April-June 2010): This phase began with the team's visit to Angola from April 7-21 to interview key informants, make site visits, continue information/data collection to enrich the areas of inquiry identified during Phase I, conduct a stakeholder workshop, and submission of a draft report to MINSA and USG/Angola for review and comments prior to finalization. The team included three international consultants supported by USAID/Angola health unit staff. Over May-June the draft report was reviewed by USG, MINSA, UN agencies and others. The team addressed the feedback and finalized this English version of the report.

COUNTY OVERVIEW

Angola is one of the Africa's largest, resource-rich countries in the region. The country has a population of approximately 17 million, and is distinguished by a relatively large urban population (56 percent). Angola has experienced rapid economic growth, an average of 16 percent per year from 2004 to 2008, and increasing political stability since the end of their civil war in 2002. The gross national income per capita is 20 percent higher than the average for the region, although wealth is extremely concentrated, and Angola continues to score very low on most global measures of health socio-economic development. Major causes of death in children under five years of age include preventable or easily treatable conditions such as pneumonia, diarrhea, and malaria.

TABLE 1: SELECTED INDICATORS FOR ANGOLA AND SUB-SAHARAN AFRICA REGION

Selected Indicators (2007)	Angola	Regional Average	Data Source
Total population (thousands)	16,948	17,020	WDI-2009
Population living in urban areas (%)	56	38	
GDP per capita (constant 2000 US\$)	1,265	1,003	
Life expectancy at birth (years)			http://www.who.int/gho/countries/ago
Male	51	51	
Female	55	54	
Both	53	52	
Under-five mortality rate (per 1000 live births)	158	145	
Prevalence of HIV among adults (per 100,000 adults 15 and older)	1,962	4,735	
Prevalence of tuberculosis	294	475	

Angola faces great challenges as the prolonged war left the country's infrastructure in ruins, its interior areas heavily mined, and its social, political and economic institutions largely non-functional. In order to address some of the weaknesses posed by a highly centralized government, the Government of Angola officially launched a policy of political and administrative decentralization in 2001. MINSA has taken this policy a step further through its district health strategy ("Revitalização dos Serviços Municipais de Saúde", MINSA 2008, 2009) that calls for shifting more management responsibility to Angola's 164 districts and resources to the primary health care system.

Although the Angolan health system still faces many of the same challenges that it did in 2005, there has been measureable progress and new developments in the past five years that position Angola to continue improving health system performance and health outcomes.

KEY FINDINGS

Health Service Delivery: Coverage of basic health services increased from 30 to 42 percent since 2005. Public funding of primary care facilities grew faster than any other category. Geographic access has increased thanks to the renovation and construction of health centers, in many cases based on the provincial health maps, and some experience using private sector services to reach populations. The application of health system regulations and introduction of provincial health maps (*mapas sanitários*) clarified standards for levels of care, services, and facility types that allowed objective evaluation of facility performance. Quality of service delivery is being addressed through development of clinical standards, and evolving experiences with facility accreditation. Service delivery is still afflicted by human resource issues, stock-outs of essential products, and uneven funding of recurrent costs, as discussed below.

Governance: Angola has a strong executive government structure wherein the president appoints provincial governors who in turn appoint district administrators. Parliamentary elections were successfully held in 2008 and featured visible outreach to voters, especially on the issues of housing and water. Since 2005 there has been a major thrust to implement administrative and fiscal decentralization to district and provincial governments through a strategy of "revitalization". A series of district

assessments has been completed with donor support¹ to inventory existing resources across all sectors for planning through a highly participatory process at the local level. In parallel, different structures for local accountability and voice are emerging such as water committees, district forums, and cooperatives. However, much remains to be done to ensure accountability. To inform health infrastructure investments and operational planning, MINSA has completed health-mapping exercises (mapas sanitários) for eleven of Angola's 18 provinces. MINSA's district health strategy is a commitment to primary health care and to being more pro-poor. However, it shifts significant responsibility to the district level without clarifying how capacity and resource limitations will be addressed.

Health Financing: Angola spends an estimated US\$ 72 per capita on health, about the same as the regional average. In contrast to the region, public sector financing dominates (80 percent) and Angola is less dependent on donor funds (only 7 percent of total health expenditures compared to the regional average of 22 percent). Public financing for primary care increased dramatically (415 percent) from 2000 to 2005. However public spending on health overall remains low at five percent of total public spending, far below the regional average of 9.6 percent. Management of health financing is in transition as the country implements the decentralization strategy that will shift responsibility for planning and spending health budgets to the districts. Provincial health maps are now guiding infrastructure investment and operational decisions. Public primary care facilities no longer charge user fees, but funding to replace user fee revenue has been uneven. Private health insurance options have emerged since 2005 targeting companies and upper income households. The major challenge is financing of non-salary recurrent costs (drugs, water, fuel, and supplies) at the primary care level in the face of rapid decentralization. These inputs are critical to improve service quality and avoid out-of-pocket expenditures.

Human Resources: The same human resource issues originally highlighted in 2005, are cited as major constraints in 2010: low and/or narrow clinical skills, underserved rural areas, doctor shortage, few medical schools, limited quality supervision, and few community-based health workers. Progress since 2005 includes tripling the number of doctors (up to 2,956 in 2009), building several new medical schools (though staffing is a challenge), establishing a functional payroll system (public employees generally paid on time), and including community health workers in MINSA's district health strategy. Lack of funds for recurrent costs (e.g., fuel) and vertical programming, hamper integrated supervision and training of primary care staff, and ultimately limit opportunities to increase efficiencies and address clinical realities.

Medicines and Medical Products: The National Medicines Policy was adopted in 2010 indicating the opportunity for significant improvement in medicines management. Stock-outs of medicines and commodities in the public sector to support service delivery remain a challenge. Currently, MINSA still manages the procurement and distribution, including the essential-medicines-kit program, but problems include poor information systems, delayed national procurements, lack of an operational registration system, and limited quality assurance. In the face of these challenges, provinces are increasingly managing their own medicines outside of the kits system and at least one donor has resorted to a private distribution system.

Health Information System: Angola has acquired much new and valuable health information in the form of studies of priority health issues and the provincial health maps. MINSA and donors have worked closely to build provincial and facility capacity to use data and improve data quality. MINSA is championing birth registration and maternal death audits. However, there are significant delays and restrictions on the release of public health information, and one-way flow of information hinders data

¹ The District Development Program ("PDM" in Portuguese) with 9 district profiles ("perfil municipal") (<http://www.dw.angonet.org/>)

use and quality. For example, annual health statistics reports are not available since 2007. Individual patient records are a rarity at the primary care level, making it an obstacle to ensure clinical quality. A notable gap is the lack of a national census since the 1970s. Since 2001, MINSA has endeavored to establish a single harmonized HIS and database for routine health system data. The Health Metrics Network's recently completed assessment and the district health strategy represent fresh opportunities to build a harmonized, integrated, well-used Health Information System (HIS).

OPPORTUNITIES/RECOMMENDATIONS

Based on the findings presented for the individual building blocks, specific cross-cutting opportunities and ideas for solving the problems were identified. While most of the problems are priorities for the success of Angola's district health strategy, the ideas and suggestions have merit regardless of the status of the strategy.

Financing of Non-Salary Recurrent Costs: The public payroll system functions reliably, but financing of other recurrent health expenses is inconsistent and often inadequate due to poor funding for health from the central level and insufficient allocation, planning, and spending at the sub-national levels. At the central level, one suggestion is to advocate with the Ministries of Finance (MINFIN) and Planning (MINPLAN) for full funding of approved health budgets. Many projects interventions have focused on better health planning, but advocacy may need to be elevated to a higher level to resonate with non-health experts within MINFIN and MINPLAN. Along those lines, MINSA should assert the macro-economic implications of Angola's demographic trends and the need for a strong health system to meet the demand for family planning and healthy children and mothers. MINSA and MINFIN should diagnose the causes of low budget execution. MINSA and donors' investments in building local capacity and staff motivation to prepare plans and budgets are at risk if they do not really affect actual funding. Finally, there is an opportunity for improved donor coordination and ways for partners to "speak with one voice" regarding the importance of full funding of approved budgets for recurrent health costs. At the sub-national level, ideas to facilitate the shift of responsibility for planning and spending health budgets from the 18 provinces to the 164 districts, include: clear guidance to district administrators, district health budgets based on objective criteria, central level co-financing, technical support to the district health teams, or performance incentives based on the district health strategy.

Essential Medical Products: The chronic shortage of essential medicines and supplies puts the district health strategy at immediate risk of failure. In 2010, MINSA continues to define the solution as one related to eliminating the delays in the procurement and distribution of essential drug kits. The team recommends redefining the objective to ensure a consistent supply of essential medical products in primary care facilities and looking at different solutions that take advantage of the new medicines policy and new systems to manage the supply chain. Four specific opportunities emerge:

- 1) Private sector options: Solutions may be explored that take advantage of private supply chains and financing that are more affordable, assure quality, and are responsive to community needs. Two models that are discussed are revolving drug funds and social marketing of key essential products, but there are others that may be explored for appropriateness in the Angolan context.
- 2) Strategic investments for quality assurance: Increasing access to medical products is only meaningful if the products are of assured quality in both the public and private sectors. Key components of a quality assurance system have been created within the structure of the National Directorate of Medicines and Equipment (DNME) and progress has been made in developing the capacity of staff and systems to make these components fully functional. Investments will be required for training and

equipment to support implementation at the provincial level. While MINSA has already begun to receive some assistance from its international partners, the scope is such that there will be many opportunities for support to operationalize the policy at all levels of the system. The DNME could benefit from a focal point to ensure that there is a strategic, coordinated approach to making optimally strategic investments in this area.

- 3) Improve the inappropriate use of medicines at all levels: Facility and community based strategies should be implemented to contain the emergence and spread of antimicrobial resistance arising from the inappropriate use of medicines, and the use of poor quality products.
- 4) Develop information systems to support transparency and accountability as well efficiencies: Finally, there is an opportunity to ensure that planned improvements in the warehousing and management of supplies include the development of an effective information system that will yield critical inventory management performance measures. Given the importance of an effective supply chain, all stakeholders should be engaged and consulted in the design, testing, and implementation.

Integration of Services at the District Level: MINSA's puts service integration at the heart of its district health strategy, however integration faces vertical donor funding, vertical central programs, and weak capacity at the local level. Several opportunities were identified: 1) national vertical programs refine their scope to focus on national functions such as strategy, national Information, Education and Communication (IEC) efforts, technical orientation, monitoring, and evaluation; while providing political support for integrated training, supervision, procurement, and information systems at the service delivery levels and delegating management and implementation to the local level; 2) human resources reforms and investments should purposefully support integrated service delivery, including motivating health workers to expand their skills and workload; 3) provincial health teams can develop and manage integrated supervision models; and 4) MINSA can harmonize information systems across vertical programs, including for medical products.

Reaching Communities and Households: There is consensus to go beyond the "fixed network" of facilities and reach the community and households with cost-effective interventions related to water, hygiene, nutrition, neonatal care, and patient follow-up. The district health strategy proposes that community health workers be managed at the district level; however the districts already face significant challenges absorbing the new responsibilities of funding and managing the facilities. The lack of clarity on the best way forward represents an opportunity to review past experiences and test new approaches as the district strategy is rolled out. The low rate of skilled birth attendance and the existence of traditional birth attendants (TBAs) supported by the Ministry of Family calls for their inclusion in any assessment of community-based approaches. Stakeholders should systematically monitor and share lessons, or even consider formal evaluation. Also, the promotion of appropriate self-care (household production of health), cannot be overlooked as a strategy to improve health outcomes that complements Angola's investment in facility-based services. Angola could use alternative channels for improving household practices such as churches, the media, and water management committees.

Donor Coordination: The district health strategy offers a clear basis for donor coordination. New health projects from the World Bank and EU explicitly reference the strategy. There are many opportunities for improved efficiencies and results. However, there is no formal body or forum for broad health system stewardship among the health sector donors. In the short run, partners should take advantage of existing bodies such as the Inter-Agency Coordination Committee for Polio and the Country Coordinating Mechanism associated with the Global Fund. Donors might also consider regular meetings among themselves for information sharing until MINSA establishes an alternative. In the long

run, a formal donor coordination body should be established, preferably informed by the MINSA study of experiences in other African countries.

Beyond the Health Sector: Although this assessment focuses on the health system, coordination across water, environment, agriculture, education, and livelihood initiatives has the potential to deliver significant health results. For example, environmental health issues (e.g. water supply, sanitation, and pollution) are significant problems in Angola. Donors and local efforts to address these problems offer opportunities to improve health outcomes, governance, and equity. Since 1999, the Luanda Urban Poverty Program (LUPP) has provided clean water at substantially reduced rates for residents, but it also provides microfinance and business development services. Success with community members contributing toward the cost of clean water suggests that patients may be open to cost sharing for responsive, quality services. Malnutrition is the main associated cause of mortality in Angola, and yet the country's vast potential for agriculture is still largely untapped. As the government of Angola and donors continue to work on developing the agriculture sector, there is an opportunity to ensure a strong link to food security and nutrition. Opportunities should also be sought to incorporate healthy living messages into other economic development and livelihood efforts. For example, the SPREAD Project in Rwanda, a USAID Agribusiness Project, has added a health promotion component to its work with coffee growers. The positive link between maternal education and maternal and child health outcomes has been well established for decades. Improvements in education could yield significant health results by improving girls' and women's education status, and therefore improving their health behaviors; and by creating a better educated health workforce, providing a stronger foundation to improve Angola's human resources for health.

PROMISING ENVIRONMENT

There is an incipient, but growing sense of state accountability to patients and community fueled by the parliamentary elections in 2008, decentralization to districts, and upcoming presidential elections in 2012. The district health strategy offers clear direction, is more pro-poor and focused on maternal and child health. Some aspects of the strategy are clear and standardized (e.g., fixed delivery system including referrals between levels, basic benefits package, need for integrated supervision, and information system at the district level). Other aspects are not clear and could benefit from experimentation and creativity such as community health workers and district health financing. There is broad agreement on the problems and even the solutions in many cases, but not always on "how" at an operational level. Public sector leaders do not always feel empowered to act and at present there is a preoccupation with planning and regulating, and less emphasis on implementation.

I. BACKGROUND

In 2005 the Partners for Health Reform *plus* project (PHR*plus*) – the predecessor to the Health Systems 20/20 project (HS 20/20) – conducted a Health System Assessment (HSA) in Angola to inform the United States Agency for International Development (USAID)/Angola's health sector programming. The HSA identified the relative strengths and weaknesses of the country's health system, which included the following:

- Lack of human and institutional capacity, especially at the provincial and district levels, for supervision, data analysis and use, and planning and budgeting;
- Insufficient and inequitable public health financing of basic inputs for service delivery (e.g., supplies, drugs, equipment, electricity, potable water) contributing to user fees being charged by some public facilities;
- Strengths included the quantity of nurses, Ministry of Health and donor plans to increase staff capacity, the motivation of public sector health staff at multiple levels, implementation of some quality guidelines (IMCI and maternal health), and public-private partnerships in health.

The HSA also prioritized specific challenges and, based on stakeholder input, proposed strategies with expected results (Table 2).

Since then, USAID has implemented a number of health projects in areas such as malaria, HIV/AIDS, family planning, and maternal and child health. Other donors such as the European Union and some United Nations agencies (WHO, UNICEF, UNDP) have also carried out major activities in Angola with MINSA. These efforts have generated rich new sources of information on the state of Angola's health system and produced some results. Currently, MINSA is in the process of finalizing a health system development plan, and USAID/Angola is considering taking an integrated approach to its health programming in the country. This is an opportune time to update the 2005 assessment to identify the main advancements since then and inform the MINSA and USAID/Angola's strategies going forward. The specific objectives of this assessment are to:

- Review new sources of data that have become available since 2005;
- Identify areas of progress since the 2005 HSA and successful strategies;
- Identify the continuing challenges to strengthen Angola's Health System, with particular attention to: human resources, health information systems (HIS), commodity security, donor coordination, and translating good planning into action. All are areas of health system weakness that continue to impede the performance of USAID programs;
- Develop recommendations to help inform the MINSA's health strategy;
- Help inform USAID/Angola's integrated health strategy.

**TABLE 2: SUMMARY OF FINDINGS, RECOMMENDATIONS, AND EXPECTED RESULTS
FROM 2005 ANGOLA HSA**

Identified Challenges	Recommended Strategies	Expected Results
Health Financing		
<ul style="list-style-type: none"> Public health funding inadequate (especially for recurrent Primary Health Care (PHC) costs) and inefficient Health plans and budgets are top-down Low capacity at provincial/district levels for planning and budgeting Little accountability for execution of health plans and budgets at all levels User fees high and not transparent 	<ul style="list-style-type: none"> Build capacity at provincial level in planning and budgeting – especially recurrent costs Monitor implementation of health plans and budgets Make user fees transparent Build local capacity to manage user fee revenue 	<ul style="list-style-type: none"> Increased capacity and accountability at all levels for programming and spending public health funds Increased financing for PHC Increased community access to PHC services
Essential Drugs		
<p>Chronic stock-outs of essential drugs due to:</p> <ul style="list-style-type: none"> Irregular financing Lack of security at regional and provincial warehouses Insufficient transport Personnel not trained in stock management 	<p>Multi-partner accord with the MINSA and MOF to secure regular MINSA financing of procurement of essential drugs in exchange for coordinated external support to build capacity and strengthen the domestic distribution system at all levels</p>	<ul style="list-style-type: none"> Accountability at the national level for regular essential drug procurement Increased capacity at all levels to store and distribute essential drugs Improved quality of PHC
Service Delivery		
<ul style="list-style-type: none"> Lack of essential drugs, supplies, equipment, water, and electricity Levels of service not clearly defined Staff not trained for service level required Staffing may not be appropriate Lack of supervision for all services and public health initiatives 	<ul style="list-style-type: none"> Donor coordination to secure national program support and leadership to implement actions Capacity building in selected provinces to implement actions: <ul style="list-style-type: none"> Formative supervision On-the-job training Monitoring of quality of care and patient satisfaction Update curriculum 	<ul style="list-style-type: none"> Increased accountability at the national level Increased capacity at the provincial level to improve quality of PHC Improve accountability of service delivery to community Increased quality and availability of essential services
Private Sector		
<ul style="list-style-type: none"> Health system not accountable at the community level Private providers increasing – to serve whom? Harnessing corporate resources for public health 	<ul style="list-style-type: none"> Citizen's board for health centers MINSA contracts with not-for-profit and/or private providers Micro-credit for private providers Coordination among companies and with donors and the MINSA 	<ul style="list-style-type: none"> Increased community participation and health system accountability Increased private participation to serve target populations More effective, coordinated participation of companies in public health
Health Information		
<ul style="list-style-type: none"> Very limited data (surveys) Routine data quality unknown Lack of forms, calculators and supervision at lower levels Parallel information flows Information not used at lower levels 	<ul style="list-style-type: none"> Move forward with plans to conduct: <ul style="list-style-type: none"> DHS Facility mapping Study the cost of primary care Census 	<ul style="list-style-type: none"> Improved availability of reliable data for informed decision-making

2. COUNTRY OVERVIEW

2.1 GENERAL

The Republic of Angola is located on the west coast of sub-Saharan Africa (SSA). It is one of the largest countries on the continent, with a surface area of 1.2 million km. Its growing population is estimated at 17 million inhabitants (WDI 2009; 2007 estimate), of whom about 44 percent are less than 14 years old and 57 percent are urban (CIA World Factbook, 2009 estimates). The country is multicultural and multi-linguistic. More than 18 national languages are spoken, but Portuguese is spoken by a majority of the population. Modernity and ancestral ways of life coexist. Politically and administratively, Angola is divided into 18 provinces, 164 districts, and 557 communes.

Box 1: Making Health a National Priority

Current demographic trends will strain Angola's macro-economic and political stability unless the government invests in reproductive health and the health system in general.

The current high fertility rate and young age distribution found in Angola are predictive of accelerated population growth, as a significant proportion of the population is entering reproductive age. Angola is blessed with ample arable land and average population density is low. But averages mask acute overcrowding in urban areas and the limited ability of the country's infrastructure (water, sanitation, housing, education, health) and job market to absorb rapid population growth.

While difficult to confirm in the absence of a DHS or similar survey, contraceptive prevalence has remains low at 18 percent (UNICEF 2008). There is evidence of unmet demand for family planning from health facilities (patients asking for contraceptives) in a recent social assessment, "Women complained about their excessive number of pregnancies" (World Bank 2010).

Angola gained independence in 1975, following 500 years of Portuguese rule and 14 years of armed struggle between the colonizers and the Angolan nationalist movement. The nationalist groups were unable to share power upon independence. With the support of Cold War sponsors and mineral wealth, the groups engaged in a brutal civil war that lasted 27 years. All told, as many as 1 million Angolans were killed, 4.5 million became internally displaced, and another 450,000 fled the country as refugees. The two largest groups to emerge during this time were the *Movimento Popular de Libertação de Angola* (Popular Liberation Movement of Angola, or MPLA in Portuguese) and the *União Nacional para a Independência Total de Angola* (National Union for the Total Independence of Angola, or UNITA in Portuguese). The battle between these groups lasted until the death of UNITA's leader in 2002. MPLA's José Eduardo dos Santos has been president since his selection by the party in 1979, and his reelection in 1992

in the country's first multi-party election. Legislative elections were held in 2008 and presidential elections are scheduled for 2012. A new constitution was passed in January 2010.

The prolonged war left the country's infrastructure in ruins, its interior areas heavily mined, and much of its social fabric in tatters. Political and economic institutions, which during colonial times were centralized to serve the interest of a select elite, remained centralized. Angola falls near the bottom of most global measures of socio-economic development. The U.N. Development Program's (UNDP's)

2007 Human Development Index places it 143 out of 182 countries, in a slight improvement from 2003's 160 out of 177. While the World Bank estimates gross national income per capita at \$5,030, relatively high for SSA; however 70 percent of Angola's population lives on less than US\$ 2 per day (UNDP Human Development Report 2009). Annex A presents a series of comparative indicators for Angola and SSA: economic, governance, health financing, human and physical health resources, pharmaceutical, private sector, and HIS.

Angola is enormously in natural resources. It is the world's fourth largest producer of rough diamonds; diamonds represent 95 percent of non-oil exports, and gross revenue from diamond sales has effectively doubled, from US\$ 638 million in 2002 to US\$ 1.2 billion in 2006, while government income has more than tripled, from US\$ 45 million to US\$ 165 million over that same five-year period (Partnership Africa Canada 2007). Angola is the second largest oil producer in SSA and the seventh-largest supplier to the United States. Oil production currently stands at 2 million barrels per day and is rising, and along with its supporting activities contributes about 85 percent of gross domestic product (GDP) (CIA World Factbook) and about 75 percent of government revenue. Angola's GDP has grown quickly, averaging 16 percent per year from 2004 to 2008, slowing down in 2009 due to the drop in oil prices. The country's rich natural resources and the spurring economic growth and increasing political stability since the end of the war present a unique opportunity for progress and prosperity.

2.2 HEALTH

2.2.1 HEALTH STATUS

The availability of health status data in Angola is limited. There has been no Demographic and Health Survey in the country and the last reliable national-level source for health indicators was the Multiple Indicator Cluster Survey (MICS) in 2001. Although the final report of the new MICS (*Inquérito sobre o Bem-Estar da População*, or IBEP) conducted in 2008 has not yet been released, preliminary data from this survey is available (see corresponding indicators in Tables 3 & 4).

Angola's maternal, child and reproductive health indicators are some of the worst in SSA. The maternal mortality ratio was estimated to be 1,400 maternal deaths per 100,000 live births (World Development Indicators 2009). The infant mortality rate has been reported as 150 per 1,000 live births in 2007 (World Development Indicators 2009) with the under-five mortality rate being reported as 195 per 1,000 live births in 2008 (IBEP, UNICEF 2008). The total fertility rate is estimated to be 5.8 births per woman (UNICEF 2007). Although contraceptive prevalence (all methods) has improved significantly since 2001, it is still low at 18 percent (IBEP, UNICEF 2008).

The estimated average life expectancy is only 38.2 years for men and 42 for women. Malaria is reported to be the principal cause of mortality and morbidity in the country, with a total 3.25 million cases and 38,000 deaths due to malaria reported in 2003 (Angola Malaria Indicator Survey, USAID, 2006-7). A small number of diseases, namely malaria, acute diarrhoeal diseases, acute respiratory infections, measles, and neonatal tetanus, are directly responsible for 60 percent of child deaths, despite the fact that it is relatively easy to prevent or treat these problems at the level of primary health care services, and through better practices and care at household level (MINSA 2004b). Malnutrition is the main associated cause of mortality for children under five years of age (UNICEF, MINSA, DNSP. 2007).

TABLE 3. HEALTH STATUS INDICATORS

Indicator	Measure	Angola		Sub-Saharan Africa	
		Source	Data	Source	Data (year)
Life expectancy	Life expectancy at birth (years)	WHO 2004	38 (male) 42 (female)	WHO 2004	47 (male) 49 (female)
Infant mortality rate	Infant deaths per 1000 live births	MICS 2001 IBEP 2008	115.7 150	WDI 2009	79 (2007)
Under-five mortality rate	Child deaths per 1000 live births	MICS 2001 WDI 2009 (2007 data) IBEP 2008	250 158 195	WDI 2009	124.9 (2007)
Maternal mortality ratio	Maternal deaths per 100,000 live births	UNDP2007 WDI 2009	1400 - 1700 1400	WDI 2009	832 (2005)
Fertility rate	Number of births per woman through the end of childbearing period	WHO 2004 UNICEF 2007	6.7 5.8	WDI 2009	4.9 (2007)
Prevalence of underweight children under-five	Low weight by age is > 2 standard deviations from average	MICS 2001 UNICEF 2007	31% 16%	WHO	24.9 (2001)
HIV prevalence	Prevalence of HIV among adults (15-49 years old)	UNGASS 2010	2.0%	UNAIDS 2008	5.75 (2007)

There are a series of contributing factors to the poor health indicators that relate to health services and the health system, household health practices, poverty, and the environment. Table 4 displays selected health service indicators of health system performance.

TABLE 4. HEALTH SERVICE INDICATORS

Indicator	Measure	Angola		Sub-Saharan Africa	
		Source	Data (year)	Source	Data (year)
Doctors in the public sector	Doctors per 100,000 inhabitants	MINSA WHOSIS	7.7 (1997) 5 (2000 ^a)	HDR WHOSIS	32 (1991) 16 (1995-2003)
Access to drugs	% of the population with access to essential drugs	WHO	20 (2001)	n/a	n/a
Vaccination coverage for diphtheria, whooping cough, and tetanus (DPT) (3 rd dosage)	% of children 12-23 months vaccinated	MICS WHO	24 (1996) 34 (2001 ^b) 83 (2007)	SOWC ^c	46 (1999) 85.2 (2007)
Vaccination coverage for polio	% of children 12-23 months vaccinated	MICS	28 (1996) 63 (2001 ^b)	SOWC ^c	48 (1999)

Deliveries in health facilities	% of deliveries attended by trained health personnel	MICS WDI-2009	22 (1996) 45 (2001 ^b) 47.3 (2007)	SOWC ^c WDI-2009	39 (1995-2000) 59.1 (2007)
Pre-natal consultations	% of pregnant women who attend one or more pre-natal consultations	MICS IBEP 2008	64 (1996) 66 (2001 ^b) 69 (2008)	SOWC ^c	64 (1995-2000)
Contraceptive use	% of women of reproductive age who use any method of contraception	MICS IBEP 2008	8 (1996) 6 (2001 ^b) 18 (2008)	SOWC ^c WDI-2009	22 (1995-2000) 15.8 (2001)
<p>Notes: WHOSIS = World Health Organization Statistical Information System, HDR = Human Development Report (U.N. Development Program), MICS = Multiple Indicator Cluster Survey, SOWC = State of the World's Children (UNICEF), WDI = World Development Indicators. IBEP = Inquérito sobre o Bem-Estar da População, UNGASS = United Nations General Assembly Special Session (UNGASS) on HIV/AIDS.</p> <p>a) Estimate based only on doctors in the National Health Service, as published in <i>Anuário Estatístico do MINSA</i> (MINSA 2000).</p> <p>b) MICS 2001 (Malaria Operational Plan 2003) only covered areas accessible during the war.; c) UNICEF (2002).</p>					

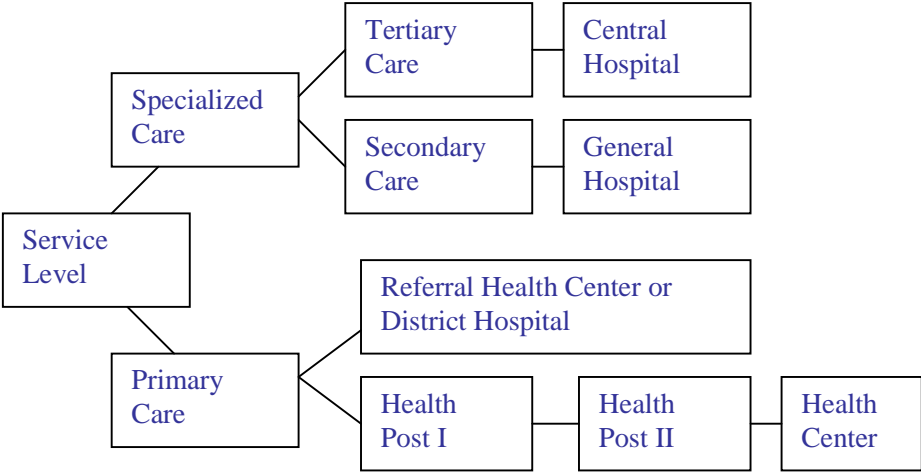
Angola's epidemiological profile is still dominated by diseases and health conditions that can be largely impacted at the household level. The limited data available on household production of health indicates a need for greater health promotion to improve knowledge, attitudes and practices (KAP) in health. For example, according to the Angola Malaria Indicator Survey 2006-7, only 20.7 percent of children under five years of age were sleeping under a mosquito net. On reproductive health, in a KAP survey conducted by the USAID-funded ESD project in the Luanda province in 2009, the reason mostly cited by women for not using contraceptives was lack of knowledge (33 percent), followed by disapproval from mother-in-law (32 percent), disapproval from husband (29 percent), and privacy/confidentiality concerns (26 percent). On nutrition, only 31.1 percent of mothers exclusively breastfed their babies until six months of age; although still low, this marks an improvement from 14 percent in 2001.

Environmental health problems continue to be a significant burden for Angola. Forty-two percent of the population has access to an improved drinking water source and 60 percent have are using an improved sanitation facility (IBEP, UNICEF 2008). Semi-urban populations live near mounds of uncollected rubbish and stagnant water. Less than a quarter of the population of Luanda is served by a sewage system (Hodges 2004). Based on an analysis of registered deaths in Luanda, the government's accelerated plan to reduce maternal and child mortality (MINSA 2004b) observed that, "...environmental causes are more important than biological causes in determining the mortality of Angola children."

2.2.2 HEALTH SYSTEM

MINSA structure remains the same as in 2005 (Figure 1). Health service delivery is divided into three levels of care (primary, secondary, and tertiary) corresponding to the three levels of government (district, provincial, and national). The MINSA carries out its stewardship and technical guidance role through a variety of departments (e.g., department of planning known as GEPE) and national vertical health programs supported by partners such as the EU, UN agencies and the US government. The provincial and district governments are experiencing a major transition as the health system decentralizes responsibility for primary care from the provincial to the district level.

FIGURE 1: HEALTH SERVICE DELIVERY LEVELS



Angola inherited a colonial health system that catered almost exclusively to the colonizers and was inappropriate to address the health needs of the local population. The prolonged war that erupted upon independence hampered the development of a proper health system until very recently, when the war finally came to an end. After decades of destruction, in the first few years of peace there was a rush to invest in the development of the health sector. However, this investment did not necessarily match the health priorities of the population, since it was carried out without much information or planning (MINSA 2008). In the past five years, major developments in the Angolan government and in donor assistance have begun to steer the Angolan health system into a more informed and systematized strengthening strategy.

In 2001 the GOA officially began the process of decentralization, but this process did not materialize in the health sector until a few years later. The health system has now taken the first steps towards decentralization, such as shifting responsibilities and decision-making down to the provincial and district levels from the central level. With support from the EU and UN agencies, MINSA has developed a detailed district health strategy, which will guide its decentralization process. At the core of this strategy is a shift from vertical programs to integrated care. MINSA is also in the process of conducting comprehensive provincial health profiles (Mapas Sanitários), providing an unprecedented amount of information that is being used to inform the district health strategy. Meanwhile, USAID investment is building capacity at the district level (in the health sector and beyond) to plan, manage, and deliver better services.

The Government of Angola has also invested heavily in infrastructure in the past five years. New roads have significantly improved time and safety of transportation within the country, and hundreds of new health facilities have been built throughout the country (Table 5).

**TABLE 5: CONSTRUCTION OF HEALTH FACILITIES IN FIVE PROVINCES
1976-1999 AND 2000-2006**

Province	1976-1999	2000-2006	Total
Luanda	18	28	46
Benguela	18	50	68
Huambo	6	90	96
Bié	3	25	28
Huíla	33	66	99
Total	78	259	337
Source: MINSA and PASS 2008			

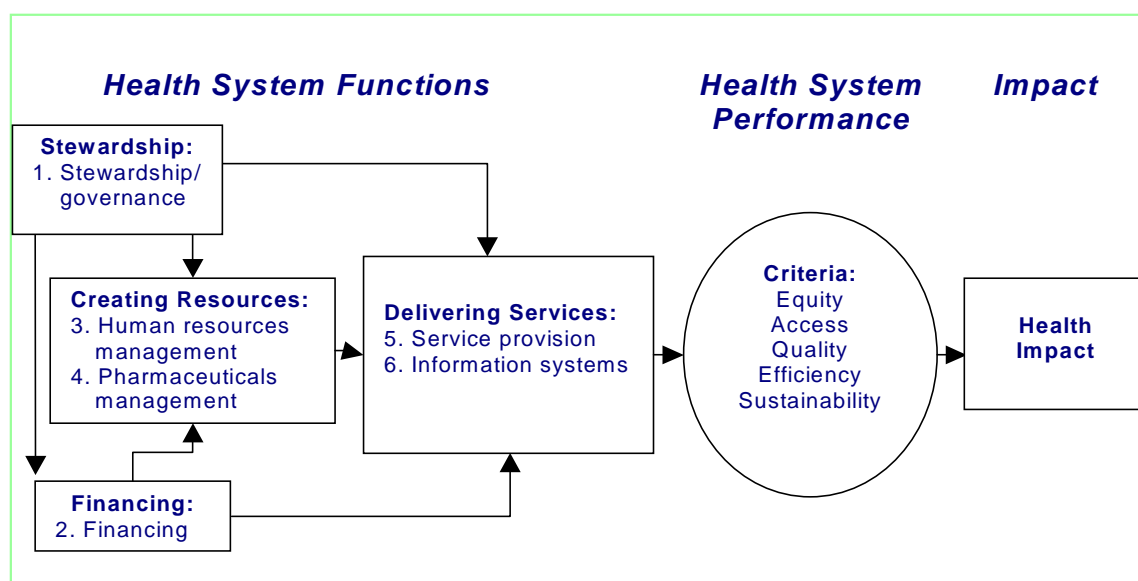
Although the Angolan health system still faces many of the same challenges that it did in 2005 the developments in the past five years are important steps in positioning the MINSA to effect meaningful and lasting change.

3. METHODOLOGY

3.1 FRAMEWORK FOR THE HEALTH SYSTEMS ASSESSMENT APPROACH

The assessment was adapted from USAID's *Health Systems Assessment Approach: A Manual* (Islam 2006), which has been applied in at least fourteen developing countries. The HSA Approach is based on the WHO health systems framework of the six health system functions (WHO 2000), later known as “building blocks”. See figure below. The assessment methodology consists of an analysis of the country's performance according to a set of internationally recognized indicators, a desk review, key informant interviews, and a stakeholder workshop to validate preliminary findings and discuss recommendations.

FIGURE 2: THE WHO FRAMEWORK OF THE SIX HEALTH SYSTEM FUNCTIONS



As a *rapid* assessment, the team does not collect any primary quantitative data. The team consolidates and analyzes the available data across all components of the health system to assess how the health system is performing as a whole and identify obstacles and opportunities that cut across multiple health system components.

This approach was adapted to the specific expectations of USAID/Angola in 2010 as documented in the team's scope of work (Annex D). It was unique in that a similar assessment was done in 2005 using a pilot version of the HSA methodology. USAID/Angola wanted the 2010 assessment to to:

- Review new sources of data that have become available since 2005;
- Identify areas of national progress since the 2005 HSA and successful strategies;

- Identify the continuing challenges to strengthening Angola's Health System, with particular attention to: human resources, HIS, commodity security, donor coordination, and translating good planning into action;
- Develop recommendations to help inform the government's health strategy;
- Inform USG/Angola's new health strategy to be developed internally in July 2010.

3.2 PHASE 1: DOCUMENT REVIEW AND INTERVIEWS

The first phase of the Angola assessment consisted of desk research. Background documents (see Annex G) about Angola generally, and the health system specifically, were identified via internet research, recommendations from USAID/Angola, USAID/W, and key informants contacted prior to the visit to Angola. Data for 80 indicators from WHO, World Bank, DHS, UNICEF, UNAIDS, and other international sources were compiled from the Health Systems Database (www.healthsystems2020.org), including benchmark averages for a regional comparator group, Sub-Saharan Africa, and a income comparator group, lower-middle income countries (see Annex A).

The team held two conference calls with the USAID/Angola health team, and met with several staff at USAID/W in Africa Bureau, Office of HIV/AIDS, Bureau of Democracy and Governance, and others with long term experience in Angola. An initial round of key informants was identified and USAID/Angola graciously assisted in setting up meetings.

3.3 PHASE 2: IN-COUNTRY

Over the course of 14 days, the in-country assessment team interviewed numerous stakeholders at the national, provincial, district, and facility levels (see schedule on page 28). Responses were hand-recorded by the interviewer in notebooks and examined for identification of patterns across stakeholders. The team visited primary care facilities and public health authorities in two provinces (Luanda and Huambo), two project sites (USAID's Essential Services Project "SES" and Pathfinder Project), and attended part of a three-day civil society forum that brought together more than 20 local NGOs involved in HIV/AIDS. The team also coordinated with the President's Malaria Initiative (PMI) staff that was in Angola at the same time to compare findings on pharmaceutical issues.

Each team member summarized findings for her assigned modules, and then the entire team summarized the results, highlighting key findings across health system performance indicators, and developed recommendations. Preliminary findings and recommendations were presented at the same time to USAID/Angola and MINSA. On the 13th day of the visit, a workshop was held at MINSA for approximately 40 stakeholders. Participants included representatives from USAID/Angola, MINSA, donors, UN agencies, private sector, non-governmental organizations (NGOs) and community organizations (see Annex C).

Health Systems Assessment for Angola In-Country Schedule April 5-21, 2010						
Sat	Sun	Mon	Tues	Wed	Thurs	Fri
		5 Team departs for Angola	6	7 Arrival in Luanda 15:30 USAID In brief with Bart, Domingas, Giselle 16:30 Security Briefing	8 9:00 WHO 10:30 UNAIDS 12:00 UNICEF 14:30 Pathfinder Project 16:00 Essential Health Services Project (SES)	9 9:00 Consaúde 11:00 DPS Luanda 14:00 WHO/Geneva team for HR 16:00 USAID conference call re HIV/AIDS costing
10 Draft Report	11 <i>Denis, Maria and Giselle depart for Province visit to Huambo</i>	12 8:30 10:00 MINSA 12:00 Visit with MINSA PMU for Global Fund 14:00 USAID Prepare agenda for stakeholder workshop	13 <i>Catherine and Ana Johansen (USAID), and Sanson (SES) visit Viana</i> RMS (District Health Team) Posto Km30 Centro de Saúde 500 Casas	14 9:30 GEPE Aran Palao 10:00 GEPE Daniel Antonio 11:00 INLS 12:00 Visit workshop venue 14:00 WHO Dr. Coulibaly 16:00 USAID D&G Officer Ronca 18:00 Team meeting	15 8:30 Civil Society Forum ANASO 9:00 MINSA RH/FP 10:00 MINSA PMU for Global Fund 14:00 EU Prepare draft presentation for stakeholder workshop	16 9:00 Directorate of Medicines 9:00 ANASO 10:00 GEPE 12:00 Coordinator of District Revitalization 14:00 MINSA Human Resources Prepare materials for workshop
17 Draft Report	18 15:00 Meeting with USAID/Angola and MINSA to revise workshop presentation	19 9:00 Development Workshop Prep for stakeholder meeting	20 Stakeholder meeting 8:30 – 14:00 Debrief Mission	21 Team departs	22	23

4. TECHNICAL MODULES

4.1 GOVERNANCE

Governance in health systems is about developing and putting in place effective rules for policies, programs, and for how activities related to achieving health sector objectives are carried out. These rules determine which societal actors play which roles, with what set of responsibilities, related to reaching these objectives. According to the conceptual framework of governance for this assessment (Brinkerhoff et al. 2008) health governance involves three main sets of actors:

State Actors: Whether politicians, policy-makers, and other government officials, these public sector health bureaucracy actors are central. They include the health ministry, health and social insurance agencies, and public pharmaceutical procurement and distribution entities. However, other public sector actors beyond the health sector can play a key role as well. These can include, for example, parliamentary health committees, regulatory bodies, the Ministry of Finance, various oversight and accountability entities, and the judicial system.

Health Service Providers: Depending upon the particulars of a given country's health system, this set mixes public, private, and voluntary sector providers. The provider category also includes organizations that support service provision: insurance agencies, the pharmaceutical industry, and equipment manufacturers and suppliers.

Beneficiaries, Service Users, and the General Public: This set can be categorized in a variety of ways: for example, by income (poor vs. non-poor), by location (rural vs. urban), by service (maternal and child health, reproductive health, geriatric care), by disease or condition (HIV/AIDS, TB, malaria, etc.) or by cultural beliefs (allegiance to particular values and customs).

In most developing countries, donor agencies represent a fourth type of actor who can have significant influence on other actors and health system performance. For example, external funding represents on average 22 percent of total health expenditures in SSA countries, albeit only seven percent in Angola.

The evaluation of governance refers to how well these actors are able to carry out the activities that cut across all other components of the health care system. Criteria used to evaluate governance at the macro-level include voice and accountability, political stability, government effectiveness, rule of law, regulatory quality, and control of corruption. Using this framework, this section will describe governance in the Angola public health system.

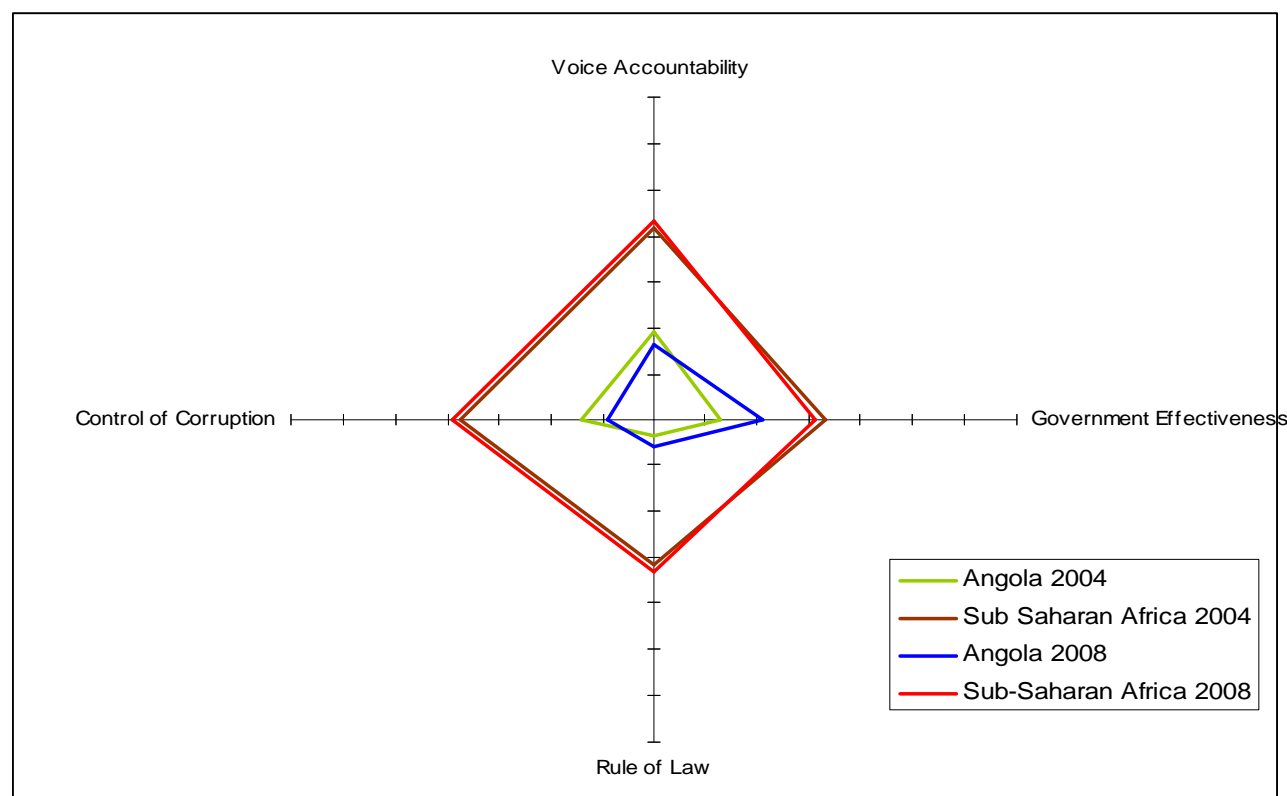
TABLE 6: WHAT'S NEW SINCE 2005 IN GOVERNANCE

2005	2010
<ul style="list-style-type: none"> • Existence of a law calling for decentralization of some government functions (DL 17/99) <ul style="list-style-type: none"> - No defined strategy for implementation - Lack of sufficient legal and regulatory support for implementation - No information to guide decision making - Poor international standing on governance 	<ul style="list-style-type: none"> • Implementation of district level fiscal decentralization (DL 2/07) <ul style="list-style-type: none"> - District health strategy identified and implemented - Increased civil society activity - Some improvements on international rating for government effectiveness and rule of law - New constitution commits to policies that promote free primary care services

4.1.1 OVERVIEW

Angola continues to rank poorly on indicators taken from the Corruption Perceptions Index (CPI), both in terms of absolute value and compared to SSA. While there was an improvement in scores for indicators for government effectiveness and rule of law, value on indicators related to voice accountability and control of corruption declined in Angola while there was a slight improvement in the region on these indicators. The indicators for quality of law and contract enforcement, police, and the level of violence are particularly low.

FIGURE 3. SELECTED GOVERNANCE INDICATORS FOR ANGOLA AND SSA



Source: World Bank Governance Indicators 2004, 2008

It is generally recognized that the nearly 30 years of civil war following independence severely cripple the evolution of democratic practices and institutions. Given the precarious political, social and economic context of the time, the regressive allocation of public assets and resources to an elite minority, at the expense of the larger society, could be understood.

The political structure of the Angolan government by level is presented in Table 7 along with the corresponding structure of the health system. The president and parliament are elected at the national level but all state actors below are appointed with the exception of local traditional leaders who inherit their positions. This structure reflects the national development strategy of fiscal and administrative decentralization that deliberately does not include a corresponding political dimension at the provincial and district levels. The implementation of the decentralization policy is witnessed in the social sectors, including health through a process of “district revitalization”.

TABLE 7: ANGOLAN POLITICAL STRUCTURE AND PUBLIC HEALTH SERVICE DELIVERY SYSTEM BY LEVEL

Level	Political Structure		Health System ^a	
	Executive	Legislative	Governance	Health Facilities
National	President: Elected Ministries by sector are appointed by the President	National Assembly: Elected Parliamentary commission on health, environment, and social affairs	Ministry of Health responsible for policy/planning, regulation, training, public health programs, procurement of essential drugs	National and specialized hospitals
Province (18)	Governor appointed by the President Governor appoints staff to provincial directorates for each sector (health, education, etc.)	None	Provincial health directorates responsible for provincial and district hospitals, health centers and posts.	Provincial hospitals
District (164)	Administrator appointed by the governor District management team for social services (health, education, other)	Emerging	District health management teams sections have line responsibility for health centers and posts	District hospitals and health centers
Communes	Appointed by district administrator, or hereditary (Souba)			Health posts
a) Does not include the military health system, which accounted for six percent of public health expenditures in 2001				

Various international donors support the development objectives of the Government of Angola. The Inter-Agency Coordination Committee (ICC) continues to be cited as the most regular and well functioning body for donor coordination. The ICC currently is primarily responsible for coordinating polio eradication activities and includes MINSA level authorities, WHO, UNICEF, Rotary International, USAID and the CORE group of NGOs.²

4.1.2 DECENTRALIZATION AND DISTRICT REVITALIZATION

The last five years have been witness to a major thrust to implement national development policies of administrative and fiscal decentralization³ that began when the Government enacted the Local Administration Decree in 1999 (Law 17/99). The style for implementing the decentralization policy can be described as incrementalist, meaning that significant components for the strategy are defined and implemented in a step-wise fashion.

As part of a broader administrative reform in 2001 (*Reforma Administrativa do Estado*), the responsibility for planning and implementing social sector services delivery was decentralized to provincial governments under the auspices of governors appointed by the President. This transfer of responsibility was not accompanied by any specific or prescriptive guidance on how to carry out this responsibility and provincial governors were essentially given full discretion to execute their allocated budgets as they saw fit.

In August 2007, the “*Plano de Melhoria da Gestão Municipal*” (Plan to Improve District Management), (Shaxson et al. 2008) was approved (Decree 2/07). This document defined the role of the district as the basic unit responsible for the management of services in the district. The district administrator, appointed by the Provincial Governor, is to be supported and counseled by a health management department (*Repartição Municipal de Saúde* or RMS). The district administrator appoints the members of the RMS. This document also recognizes consultative forums (*Conselhos de Auscultação e Concertação Social* or CACS) as community authorities, as well as traditional leaders (*souba*), as the interlocutor between civil society and state organs. As *soubas* receive monetary incentives from the General State Budget (OGE), however, they are in effect still government representatives more than they are community representatives.

Districts became budget units (which can spend funds autonomously, without seeking authorization from an overseeing institution) for the first time in 2008 and 68 districts were chosen to pilot this fiscal de-concentration. In 2008 and 2009 these districts received US\$ 5 million, regardless of size, and technical assistance from UNDP for the development of district strategic and operational plans (district profiles) under the District Development Program co-funded by USAID, Chevron, and others. Under this initiative, the RMS is charged with developing the health sector plans and advocating for their implementation to the district administrator.

² The CORE (Child Survival Cooperation and Resource) group of NGOs is a Group of NGOs and donors that works on specific issues like polio or HIV/AIDS.

³ Administrative decentralization involves placing substantial planning and implementation responsibilities in the hands of civil servants at the grassroots who fall under the jurisdiction of elected local governments. Fiscal decentralization entails according substantial authority for revenue and expenditure to intermediate and local governments. Decentralization in Angola takes the form of de-concentration whereby many functions and responsibilities, such as those associated with budget execution, are transferred to lower levels but without any corresponding decision making authority.

TABLE 8: KEY POLICIES, LEGISLATIONS, AND STRATEGIC PLANS

Key Policy/Legislation/ Strategic Plans	Description
Lei 9/75	The National Health Services created
Lei 1992	Law on Associations limits ability of civil society organizations to influence public policy
Decreto lei 1993	Regulates the activity of civil society organizations, include a number of provisions that limit freedom of association
Law n° 21-B/92 of August 21, 1992	Known as the Law of the Basis of the National Health System refers to the reorganization of the national health services in light of the new health financing scheme that foretells of user-fees.
Decreto lei 15/96	Set out the principles governing the National Statistical Council (CNE) and the National Statistical Institute (INE),
Decreto lei 17/99 and revision	Created the legal framework for decentralization
Decreto n° 54/03	Regulated each level of the National Health System (REGUSAP)
2004/2005	Poverty reduction strategy adopted/modified. The states goals are social inclusion, rehabilitation, reconstruction, economic stability, increasing access to education, health, and other basic services
Decreto lei 2/07	Created the District Health Management Teams and strengthens the status of the provincial governors and districts as de-concentrated units
Decreto lei 8/08	Designated districts as status of budgetary units. 68 districts were selected to pilot the system of fiscal de-concentration.
EU-GOA Country Strategy 2008-2013	Described the National Indicative Program for EU funding, with governance and economic and institutional reform, human and social development and rural development, agriculture and food security
2010 Constitution; Article 21 (f) "State Duties"	States as responsibility of the government to promote universal and free primary health care

4.1.3 VOICE

Voice within the context of governance refers to the ability of individual beneficiaries/patients to express their group interests in an organized fashion that can then be "heard" by the government. In Angola, civil society in general has been characterized as evolving, but is still weak, a phenomenon that can be observed within the health sector. Decentralization and the emergence of district forums and community committees are indicative of this evolution.

Two major coordinating organizations have been growing and developing capacity in the last 20 years: the Committee of NGOs in Angola (CONGA) and the Forum of Angolan NGOs (FONGA), which led the first conference of Angola civil society. In addition, the Angolan Network of Organizations for AIDS Services (ANASO) is an NGO consortium that has matured enough to receive funds directly from international organizations.

There are many other smaller NGOs and organized groups, indicating a general growth, or a maturing of civil society. Among these are youth groups, water committees and housing associations. In principle, these organizations now have a space to express voice and feed into communal and district planning through the Consultative Forums (CACs). According to key informants, there is a growing sense of the state's accountability to the population, especially with respect to water and housing, and it is hoped that it will carry through to the upcoming Presidential elections in 2012. Decentralization to the district level as opportunity to strengthen voice as the community is closer to a state representative who is more empowered. Emergence of district forums and community committees, for example for water

management, as a precursor to elected councils. On the other hand, it also becomes more labor intensive to mobilize 164 districts than 18 provinces. NGO coordination at the district level is one of the proposed roles for the RMS under the district health strategy (see Box 7 in Service Delivery section), and if this role is materialized, it could help strengthen the community mobilization capacity at that level.

4.1.4 RESPONSIVENESS

Responsiveness refers to the ability of the government to “hear” and act on expressed voice. Here, as in the case with voice, there is a mixed case. Although the constitution provides for freedom of expression, there are more opportunities to express voice, and the capacity to do so has improved, however anti-defamation statutes protect officials from reporting deemed “offensive”. Nevertheless, the parliamentary elections of 2008 were notable as several private newspapers and radio stations did carry criticism of the government.

The district health strategy may be considered a considerable step forward in developing a transparent and responsive approach to addressing health sector goals, planning, budgeting, expenditures, and data. There are currently no formal mechanisms to ensure that the appointed officials responsible for implementing the decentralization policy solicit input from the public and concerned stakeholders (vulnerable groups, groups with a particular health issue, etc.) about priorities, services, and resources. For example, stock-outs of medical products may be a concrete issue to elicit community input.

As provincial appointees, district officials are not directly accountable to the public. Presumably, if they were democratically elected officials, a more dynamic interaction would be stimulated. The closest to a popular or community based representation is the CACS, which is still a relatively new entity in most districts, and the traditional leader (*souba*) whose position is hereditary, but, as mentioned above, whose position may be considered compromised by virtue of receiving monetary incentives that flow directly from the OGE. Assuming that decentralization/ revitalization will continue to gain momentum, and civil society organizations increase their capacity to express voice, the public and other stakeholders will likely increase their capacity to hear and be responsive.

4.1.5 TECHNICAL OVERSIGHT

MINSA carries out its stewardship and technical guidance role through a variety of departments (e.g. department of planning known as GEPE) and national vertical health programs supported by partners such as the EU, UN agencies, and the US government. The provincial and district governments are experiencing a major transition as the health system decentralizes responsibility for primary care from the provincial to the district level. MINSA’s various national, vertical programs and institutes (see organization charts under HIS and Service Delivery) are responsible for technical oversight. Examples include the Department of Reproductive Health, the National Malaria Control Program, the TB Program, and the Institute for HIV/AIDS. Each one exercises their oversight through development of guidelines (protocols and standards), analysis of health data relevant to its disease or service, training health workers, and developing forms and tools.

There are various initiatives, many donor-supported, to improve government capacity to not only develop protocols and standards but to also oversee their implementation at the different levels. The Country Coordination Mechanism (CCM), which is responsible for the coordination of technical proposals to the Global Fund has also matured notably over the past five years and have a strong leadership. The 2005 assessment highlighted the inefficiency of multiple, vertical training, supervision, and

data capture efforts. The problem is a recognized challenge for the district health strategy that calls for integration of the various vertical inputs at the district level where the clinical staff skills, supervision, service delivery, the information system, and medicine inventory should be unified.

4.1.6 SERVICE DELIVERY

Provincial and district authorities in some locations are currently being supported to develop their capacity to plan, budget, and manage health services according to their area of responsibility.

To date, health services are not organized and financed in ways that offer incentives to public, NGO, and private providers to improve performance in the delivery of health services. However, tools are being developed that may provide the basis for this in the future as the health system matures. Among these are the quality of health services delivery tools developed by USAID/Pathfinder. For more information about this, see the chapter on services delivery.

The public and other concerned stakeholders are not prohibited from meeting with managers (directors) of health facilities (hospitals, health centers, and clinics) to raise issues about service efficiency or quality. However, at the time of preparing this report, the assessment team was not aware of any formal forums for this type of meeting.

4.1.7 INFORMATION, REPORTING, AND ADVOCACY

With the support and advocacy of international and national partners, MINSA has been moving toward evidence-based planning. There are more published studies and documentation related to the status of the health system available now than in 2005. In those districts that have been receiving intensive and targeted support from donor funded programs, there is evidence that service providers have been able to use evidence on program results, patient satisfaction, and other health related information to improve the services they deliver. For example, it was observed in Huambo province that local services providers were able to use the information from the district health map and evidence on program results to lobby the provincial health authorities for improvements in the supply of basic equipment. This is an area that should remain a priority for future programming as it lends itself to stimulating increased local participation to improve initiatives.

Health facilities at the primary care level (district hospitals, health centers and posts) do not track the allocation and utilization of resources because they are not budgetary units and therefore do not control any resources. The closest they come to resource management is the drug inventory management system. Likewise, service utilization and epidemiological surveillance data are collected by the facilities, but the information does not flow back in any form that supports monitoring or decision-making. Nor are the results available for review by the public and concerned stakeholders in a timely manner (e.g., the last national health statistics report “*Anuário*” is from 2006).

Information about the quality and cost of health services is not publicly available to help clients select their health providers or health facilities. There is an area that has started to receive attention and can be considered for increased investments. It should be noted that the GOA has been investing in the development of a website and that MINSA has its own portal through this site. The intent of this effort is to increase the transparency of ministry activities and accessibility to documentation. News-clips are added on a regular basis and the web site is clearly being populated with information although it can be argued that the vast majority of Angolans will not likely be able to access or use this information for some time due to weak infrastructure.

4.1.8 DIRECTIVES, OVERSIGHT, AND RESOURCES

There are various national policies for different aspects of health services delivery in Angola. Protocols for HIV/AIDS, malaria, TB and various other illnesses and conditions have been developed, along with corresponding standards, and codes of professional conduct, including certification procedures, have been developed for and disseminated to training institutions, health service facilities, and health providers. Declarations of conflict of interest, however, have not been institutionalized. There are procedures for reporting, investigating, and adjudicating misallocation or misuse of resources. In fact, during the course of collecting information for this study, the assessment team witnessed the presentation of a formal complaint to the provincial health authorities during the regular weekly meeting with the DPS leadership regarding the illegal sale of public sector medicines in a private pharmacy. The police authorities were notified and a legal action was requested.

However, mechanisms or procedures or institutions that clients, providers, and concerned stakeholders can use to fight bias and inequity in accessing health resources or services do not exist. The position of the national government on such issues, including national priorities and overall strategic approaches to guide the development of supporting legislation and regulations, would often be expressed through a National Health Policy. In term of oversight involving other non-state actors, examples would include institutional oversight committees or ombudsman's office. There is limited civil society capacity (including professional organizations, specialized health related NGOs, the media) to provide oversight of public, NGO, and private provider organizations in the way they deliver and finance health services. This is generally recognized as an area that merits continued support.

4.1.9 DONORS AND DONOR COORDINATION

Similar to 2005, Angola still lacks a formal mechanism for sector-wide donor coordination. However, there are several existing coordination bodies:

- The ICC still cited as the most regular and well functioning body for donor coordination. The ICC consists of MINSA high level authorities, WHO, UNICEF, Rotary International, USAID, and CORE group of NGOs, although it's scope is now limited to polio eradication;
- The CCM for the Global Fund is multi-sectoral, but focused on the three diseases;
- A multi-sectoral M&E Technical Working Group reportedly meets monthly to oversee Angola's National HIV/AIDS Strategic Plan;
- Forum of Malaria Partners (*Forum dos Parceiros de Malaria*) – currently the national forum is chaired by Consaúde. This forum, originally instigated by PMI, was created to coordinate all malaria interventions. It currently meets irregularly. This forum has been recreated at the provincial level in some provinces (e.g., Huambo) where there is a heavy involvement of donors for malaria;
- National Child Council of UNICEF and 12 vice-ministers including the ministries of planning, labor, education, justice as well as health. It is reported to function well;
- At a provincial and more operational level, the Health Directorate of Luanda (DPS Luanda) has multi-partner planning among the District Health Teams (RMS), the vaccination program (EPI or "PAV" in Portuguese), USAID's SES Project, and others. Members meet regularly to coordinate activities for seven key health objectives, coordinate per diem rates, trainings, data collection, studies, dissemination events, and facility interventions to ensure consistency and synergies.

While Angola has fewer donors operating in the health sector compared to most SSA countries, weak donor coordination is a lost opportunity to leverage external health assistance to maximize its positive impact. The Donor Map and interviews with representatives reveal wide agreement on the health system's priority problems, for example human resources, information systems, and drugs. However that consensus could translate into duplicative interventions in the absence of systematic donor coordination. For example, WHO is assisting MINSA with an evaluation of human resources, the Health Metrics Network program will look at information systems for human resources, the new World Bank project has terms of reference for a preparing an HR development plan; and USG is also considering how to contribute to this area.

Donors in Angola contribute to improved governance by modeling good procurement, management, and accountability practices. Examples include the Global Fund's CCM that includes civil society representatives; PMI's inclusive planning process for the procurement and distribution of malaria medicines, and public expenditure analyses in 2004 and 2008 by the EU's PASS Project (*Programa de Apoio ao Sector de Saúde*). Experts have been seconded to work from inside the public sector, such as WHO malaria technicians in each province and former EU PASS staff at Department of Planning (GEPE), for the purpose of supporting the capacity of local champions of good governance in these institutions.

The Donor Map in Annex B summarizes the current and planned donor programs for health for USG and ten other multilaterals and bilateral agencies. It is noteworthy that both the World Bank and EU are finalizing new health projects focused on the government's district health strategy. Together, the two projects have a total resource envelop of almost US\$ 100 million, a similar timeframe of 2011 to 2014/15, and have deliberately selected different provinces – the World Bank has six and the EU has five. Project inputs are likely to be quite different, with the much larger World Bank project investing in clinical training, infrastructure, vehicles, drug buffer stock, and other “hardware” and the smaller EU project likely to be mostly technical assistance along the lines of the previous PASS project. Both projects are designed to link central and district level interventions.

4.1.10 SUMMARY

This section summarizes performance of health governance in terms of the health system assessment criteria.

TABLE 9: PERFORMANCE OF GOVERNANCE

	Equity	Access	Efficiency	Quality	Sustainability
Strengths and Opportunities	<p>Compared to 2005, there is a notable movement in GOA in general toward more transparency and strategic planning across all sectors. Due in large part to the efforts of donors, this includes an emphasis on the creation and use of an evidence base, an integral part of these planning activities, and the active engagement of the various levels of government. Although MINSA is part of this general movement, not all parts of the ministry can be said to be moving in the same direction at the same speed.</p> <p>There is a tremendous opportunity to support strengthening governance in the health system through the larger social development agenda and the fact that important donor agencies are at a point where they are revisiting their own strategic plans for the country. The existence of a single guiding National Health Policy that outlines strategic priorities and implementation strategies, including financing strategies, facilitates the development and alignment of various other health related policies. Health system strengthening activities can leverage the activities and lessons learned from the initiatives of various donors and activist groups that have been working with national and local level authorities, as well as community groups around governance issues in other sectors such as agriculture, housing and water. The role of the private sector in promoting increased transparency and accountability in terms of the planning and implementation of health services and products or of assured quality remains an open question as long as oversight mechanisms are not in place.</p>				
Weaknesses and Threats	<p>While the strategic orientation has increased and gained momentum, the capacity of those responsible for the strategic planning and implementation of plans remains weak. This is particularly true for the authorities and representatives at the district and community levels. These are no mechanisms yet to fully engage these individuals and it will take some time to build that capacity. The good news is that there are some examples of success in other related sectors, especially at the community level, that suggest that the active engagement of residents in local level governance around services is achievable in Angola.</p> <p>The nature of the coalition government makes it particularly challenging to develop such umbrella policies. This may be reflected in the lack of a sector-wide donor coordination mechanism, and the various health-related policies that emerge over time run the risk of being contradictory or competing while leaving gaps. In addition, while it may also be argued that the lack of strong directives from the national level will allow for local level prioritization and local solutions, it does not assure protections for the most vulnerable populations. This is exacerbated by the fact that corruption in government, to the lowest levels, continues to be perceived as a national problem</p> <p>Threats to stronger governance in the health sector include the underlying political fragility of the country. The importance of national elections cannot be overstated. National elections come with the “threat” of changes in the cabinet and a domino effect to the provinces. Policy development and legislative procedures can be interrupted and data/evidence that may be perceived as unfavorable can be repressed. For this reason, many initiatives in the health sector are undertaken and proceed as pilot programs, while government authorities are perceived as less than transparent.</p>				

4.2 HEALTH FINANCING

Health financing concerns the three functions of mobilization, pooling/allocation of funds and the purchasing of health services. There have been significant changes, mostly positive, in all three functions in Angola as a result of macro-economic trends and deliberate policy reforms (see Table 10). Because of the absence of some data such as household spending, and delays in the release of other data such as public health expenditures; the comparison of 2005 with 2010 reflects earlier years for which the data are available.

TABLE 10: WHAT'S NEW SINCE 2005 IN HEALTH FINANCING

2005 (ref 2000-2005)	2010 (ref 2003-2010)
<ol style="list-style-type: none"> 1. Limited public funds for primary care (25% of total public health spending in 2002) 2. Budget execution 70-80% (2000-02) 3. Investments in infrastructure without any criteria (2005) 4. Government spending on health is only 4-6% of total government spending^a (2000-2002) 5. Provinces manage budgets for operational expenses at the primary care level (2005) 6. Patients pay user fees at some public primary care facilities (2005) 7. No health insurance – public or private (2005) 	<ol style="list-style-type: none"> 1. Public spending on primary care rose 415% to capture 33% of total public health spending (2005) 2. Budget execution 62-75% (2003-05) 3. Investments in infrastructure guided by detailed 'health maps' in 11 provinces (2008-2010) 4. Government spending on health only 4.7% of total government spending (2003-06) 5. Budget management transitioning to district level for operational expenses at the primary care level (2008-2010) 6. User fees eliminated at all public primary care facilities (2008) 7. Private health insurance emerging (2009)
a) Compared to SSA average of 9% and Abuja target of 15%	

WHO is assisting the GEPE at MINSA to conduct the first National Health Accounts (NHA) in Angola for 2006 to 2008. NHA is an internationally recognized methodology for tracking all health spending in a country from sources to providers and users. Unfortunately, no preliminary data were available in time for this report.

4.2.1 OVERVIEW

Angola compares favorably with the Sub-Saharan African region for several key health financing indicators (Table 11). In 2006, per capita health spending was estimated to be US\$ 71 (WHO 2006), which is the same as the regional average and substantially above the US\$ 37 basic health package calculated by the Commission on Macroeconomics and Health. Household out-of-pocket spending is estimated to be less than 20 percent, well below the average for SSA of almost 40 percent. However, actual household spending is unknown and a small study in 2007 indicated it could be much higher (WHO Angola 2009, p. 7). Also, Angola is far less dependent on external funding for health than its neighbors, 7 percent versus 22 percent.

TABLE 11: PERFORMANCE OF HEALTH FINANCING IN ANGOLA COMPARED TO SUB-SAHARAN AFRICA

Health Financing Indicator	Angola 2006	SSA Regional Average 2006	Interpretation
Total health spending per capita (US\$)	US\$ 71	US\$ 72	Same as SSA and well above the recommended level of US\$ 37
Out-of-pocket expenditure as % of total expenditures on health	13.4%	49%	Angola less dependent on out-of-pocket spending than SSA
Donor spending on health as % of total health spending	7%	22%	Angola less dependent on external financing
Government expenditure on health as % of total government expenditure	5%	9.6%	Government far from Abuja target of 15%
Total expenditure on health as % of GDP	3%	5%	Low compared to SSA
Out-of-pocket expenditure as % of private expenditure on health (measure of risk pooling)	100%	78%	Limited private risk pooling; but public health financing can be considered a form of risk pooling
Source: WHO 2006			

Despite the significant increase in government spending on health in absolute terms, from US\$ 213 million in 2002 to an estimated US\$ 800 million in 2006, health spending as a share of total government spending stagnated at the relatively low level of four to five percent from 2003-2006. This is actually down from six percent in 2001. Spending on health as a percent of GDP also is estimated by WHO to be below three percent since 2001, compared to five percent for the region. Finally, up until very recently there has been limited risk pooling where funds pass through public or private health insurance. However, government funding of health, which is more than 80 percent of total health spending, is considered a form of risk pooling.

4.2.2 RESOURCE MOBILIZATION

Health financing can be mobilized from internal or external sources. There are three main internal sources, the government, households, and employers.

Government: The government is the largest source of health financing, estimated to be 81 percent of total health expenditures. Angola's economy grew very rapidly, 16 percent on average in real terms, from 2004 to 2008 during the years of high oil prices (IMF 2009, p. 16). This allowed government spending on health and other sectors to grow, "...by an average of 18 percent in real terms during 2006-2008" (IMF 2009, p. 7). Public health spending more than doubled from US\$ 447 million in 2005 to well over US\$ 1 billion in 2008 (see Table 12). The abrupt fall in oil prices in late 2008 led to a financial crisis in 2009. A new budget was issued in the middle of 2009 to reduce planned expenditures, particularly goods and services, and capital investment. Public health spending is estimated to fall slightly from 2008, but still be over US\$ 1 billion. An IMF stand-by arrangement (US\$ 1.4 billion loan) encourages reforms to stabilize government spending at a level that is sustainable over the long term.⁴ Fiscal reforms include constraints on spending, specifically, "Social spending will be kept at 30 percent of total expenditures, its average level in recent years. The wage bill will increase by 4 percent in real

⁴ For example, Angola is considering a sovereign wealth fund to save oil revenues when prices are high and draw from the fund when prices are low to make public spending stable and predictable over the long term.

terms to accommodate employment increases in education, health, and other social sectors. The capital budget is set to remain constant in real terms with capital spending targeted mainly at infrastructure development” (IMF 2009). GEPE, with assistance from the EU’s PASS project, completed excellent analyses of public health financing for 2000-2005 that enabled stakeholders to monitor spending against different benchmarks. However, no such analyses have been done since 2005.

TABLE 12: PUBLIC EXPENDITURES TOTAL AND HEALTH 2001-2009

Scenario 1: Health as % of total public expenditures assumed fixed at 5% 2006-2009	2001	2002	2003	2004	2005	2006	2007	2008	2009
	Actual	Actual	Actual	Actual	Actual	Est	Est	Prelim	Proj
GDP (millions of USD)	8,936	11,386	13,956	19,800	30,632	45,168	59,263	84,945	68,632
Total public expenditures (millions of USD)	4,386	5,401	6,141	7,095	10,159	14,273	20,742	35,337	29,512
Health as % of total public expenditures	6.01%	3.95%	4.86%	4.42%	4.40%	5.00%	5.00%	5.00%	5.00%
Public health expenditures (millions of USD)	264	213	299	314	447	714	1037	1767	1476
Public health expenditures per capita (USD)	19.1	15	20.4	20.8	28.8	44.7	63.1	104.4	84.8
Estimated population (millions)	13.80	14.23	14.64	15.09	15.53	15.98	16.44	16.92	17.41

Source: 2001-2005: IMF for GDP; Principia 2007 for all other data; 2006-2009: IMF and author's calculations

Households: A major change since 2005 has been the withdrawal of user fees among public facilities at the primary level (posts, centers and district hospitals). A social assessment (World Bank 2010 and PAD, p. 25)⁵ done by the World Bank indicated that consumers viewed user fees as a barrier to access services. In Huambo in 2005 where the free care policy has been followed consistently, health facilities would typically give each patient a list of supplies to buy for his/her particular treatment, contributing to a large informal medical supply market. In provinces where fees were charged, the fee levels and the use of the revenue were not regulated. Some facilities used fee revenue to cover costs that should have been covered by the province (see resource flows at the end of this section). A small study of 22 facilities in five provinces in 2005 (WHO 2009, pg. 6-7)⁶ showed that user fees represented four percent of total facility costs, an average of 23 percent of non-salary costs among all facility types, and 53 percent of non-salary costs among health centers.

The actual share of total health financing borne by households in Angola is unknown. For the first time in 2008, the MICS survey included a detailed expenditure module but the results are not yet available. The MICS 2008 results will be critical to reveal if households do pay “de facto” fees by buying medicines and supplies that are not available at the public facility.

Employers: In addition, as of 2005 all large companies were providing some health service coverage for their employees through on-site clinics, company-owned health facilities, or contracts with independent health facilities. The covered population extended to employees’ dependents and even employees of subcontractors in some cases. Public corporations such as SONANGOL and Endiama are sizeable employers that provide employee health benefits. Recently, affordable private health insurance is

⁵ Social assessment consisted of focus groups in one urban and one rural area each in the provinces of Malange and Bengo.

⁶ User-fee study funded by EU PASS Project with GEPE. Sample of 22 facilities in five provinces.

available to employers – see section below under Pooling. The upcoming NHA will estimate the share of financing from employers.

External Sources: As observed above, compared to SSA, Angola is far less dependent on external assistance, averaging seven and a half percent of total health expenditures since 1995 compared to 22 percent for SSA in 2006. The main donors are the EU, the Global Fund, the World Bank, and the USG including PEPFAR and PMI. Together, donors provide an estimated US\$ 75-80 million annually. China has also been financing the rehabilitation of health facilities as part of major infrastructure construction on roads, other public buildings, housing, and other public works. Cuba provides scholarships for medical students and some doctors, though many Cuban doctors are contracted by MINSA. In addition to multi and bilateral donors, many international NGOs and faith-based organizations continue to finance health services in Angola, often in remote areas, with their own funds and as sub-recipients of donors. Service provision tends to be coordinated with district and provincial authorities, but less so with MINSA. Faith-based organizations include St. Lucas Hospital, Caritas, and Hospital Divino Benefício that has a partnership with the Luanda Province to be staffed with government health workers.

4.2.3 RESOURCE POOLING AND ALLOCATION

Pooling: As opposed to the patient paying a provider directly, pooling resources to cover health expenditures offers the possibility of spreading the risk of incurring health costs across a group of people. Pooling can contribute to equity and access if the healthy members of the pool subsidize the sick, and the wealthy members subsidize the poor. In the absence of reliable data on private expenditures, the government is assumed to represent 80 percent of total health expenditures, much higher than the average of 50 percent in the SSA region. Public health spending funded by taxes and the sale of natural resources (e.g., oil) is the main pooling mechanism in Angola. As mentioned above, private and public companies provide health coverage for their employees and dependents. These benefits constitute small, fragmented risk pools within each company.

Since 2009, three private health insurance products have emerged including ENSA S.A. (National Insurance Company of Angola), AAA, and A Mundial Seguros S.A. ENSA offers three health insurance products to companies (group plans) and individuals (see Box 2). Most preventive health services (e.g., vaccinations and annual check-ups) and HIV/AIDS are excluded from all plans. It is not clear if family planning is covered or excluded.

Over the long term, a private health insurance market can nurture the development of local expertise in insurance design and management including skills in actuarial analysis, risk and claims management, and provider contracting. This local expertise can be valuable to a future public or social health insurance

Box 2: Private Health Insurance in Angola – the Example of ENSA

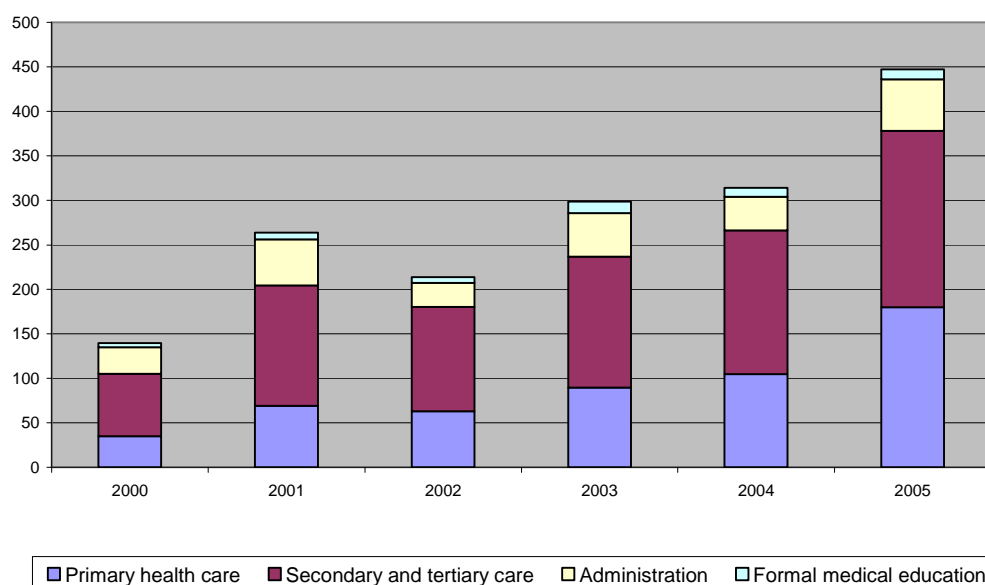
ENSA S.A. (National Insurance Company of Angola) offers three health insurance products (Complete, Normal, and Essential). ENSA prices range from US\$ 27 per month for a person under the age of 20 in an Essential group plan, to US\$ 953 per month for someone over 80 in a Complete individual plan. ENSA's Complete package covers in and outpatient services including medicines, transplants, and maternity care with an annual cap of US\$ 1 million. Only maternity care requires a cost share (20 percent). The Normal and Essential plans do not cover maternity care. An evacuation benefit for emergency services outside Angola is offered separately with all 3 plans for an additional cost of US\$ 3 to US\$ 10 per month. Use of this benefit must be pre-approved by the 24-hour call center. ENSA contracts six well-known hospitals, all private and one high-end public (Clínica Multiperfil).

program. On the other hand, in the short term, an unregulated private health insurance market can exacerbate inequities by expanding a two-class health system, as observed in South Africa (Rispel et al. 2007), or even defraud consumers and providers. There appear to be no community-based or provider-based insurance schemes.

Allocation: How public health resources are allocated has a direct impact on access, equity, and efficiency. Allocation of public resources in terms of levels of care (primary, secondary, and tertiary) impacts efficiency because from a public health perspective, primary care is more cost-effective than secondary or tertiary care. Allocation in terms of level and geography affects equity as higher income populations typically benefit more from secondary and tertiary care and live in urban areas. The MICS 2001 measured significant disparities between urban and rural populations. As of 2005, Angola had achieved progress in changing allocation patterns that hopefully will result in measurable improvements in equity, access, and health outcomes. The MICS 2008 already shows an increase in access from 30 percent to 42 percent; and may reveal other improvements when the full findings are released.

Data on actual expenditures by level of care are only available through 2005 (Figure 4). Spending on primary health care (health posts, centers, and district hospitals) grew 415 percent, faster than any other category since 2000 to capture 40 percent of the total by 2005, the second largest share after secondary/tertiary care (44 percent). However, there were wide year-to-year variations within this short period and the spending included investment as well as recurrent expenses. Informants assert that this allocation pattern has continued since 2005 with the level of funding continuing to increase each year in absolute terms until 2009 (see above section under Resource Pooling and Allocation).

FIGURE 4. PUBLIC HEALTH OPERATIONAL AND INVESTMENT EXPENDITURES IN USD (MILLIONS) BY LEVEL OF CARE, ADMINISTRATION, AND MEDICAL EDUCATION 2000-2005



Note: Primary health care includes all national programs (malaria, TB, HIV/AIDS, immunization, polio, and trypanosomiasis), essential drugs, municipal hospitals, health centers, and health posts. "Administration" refers to administrative costs borne by the provincial health directorate and at central levels. "Formal medical education" refers to medical and nursing universities and technical schools.

Source: Principia 2007.

Investment in infrastructure shows an equally positive pattern with financing for rehabilitation and new construction of the primary care network increasing in absolute and relative terms.

TABLE 13: PUBLIC CAPITAL INVESTMENT IN HEALTH 2001-2005 IN USD (MILLIONS) AND PERCENTAGES

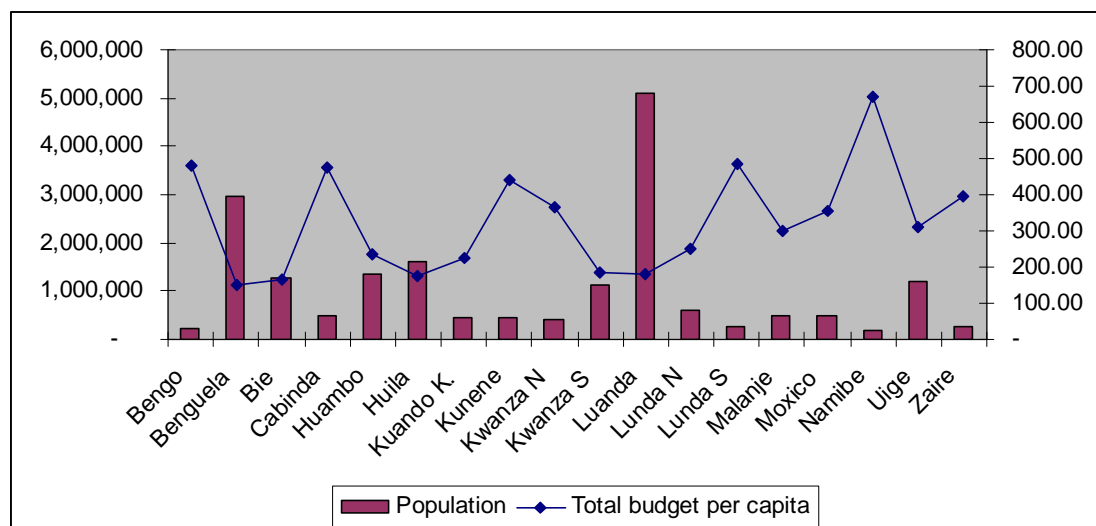
Category	2001	2002	2003	2004	2005
Primary health care	5.799	3.033	19.306	24.569	31.181
Secondary and tertiary care	21.649	6.804	9.949	24.575	44.135
Administration	1.109	0.415	1.003	0.833	0.543
Formal medical education	0.488	0.365	0	0.337	0.68
Total	29.045	10.617	30.258	50.314	76.539
Primary health care	20.0%	28.6%	63.8%	48.8%	40.7%
Secondary and tertiary care	74.5%	64.1%	32.9%	48.8%	57.7%
Administration	3.8%	3.9%	3.3%	1.7%	0.7%
Formal medical education	1.7%	3.4%	0.0%	0.7%	0.9%
Total	100%	100%	100%	100%	100%

Source: *Principia 2007*, p. 44, Table 4.5.

Concern was noted in 2005 about the lack of criteria for planning capital investments. These investments drive future spending on human resources and other operational costs and therefore have a significant long term impact on equity and effectiveness. Angola has invested heavily in construction and rehabilitation of health facilities since 2000, increasing the number of functional facilities from 78 in 1999 to 259 by 2006 (MINSA 2008). However, between 2001 and 2005, more was invested in secondary and tertiary care (54 percent) than in PHC (43 percent). Also, infrastructure investments varied widely among provinces, from less than US\$ 5 per capita in Luanda to US\$ 27 per capita in Cabinda (Principia 2007, pg. 50). With assistance from the EU, Angola has successfully completed Health Maps of 11 provinces over 2007-2010, with on-going efforts to complete Health Maps in the remaining seven provinces (see section on Service Delivery). USAID supported the most recent Health Map in Cunene Province through the SES Project. The Maps are already influencing investment decisions by linking facility location with population data, and estimating the recurrent cost implications of new or upgraded facilities. MINSA is preparing a multi-year investment plan to justify allocation of funds from MINFIN and MINPLAN, and guide annual investment budgets and spending.

In 2005, allocation of public health funds per capita varied widely by province, from a low of US\$ 5.7 in Kwanza Norte to a high of US\$ 34.7 in Namibe province. This could be due to MINFIN's practice of allocating equal amounts of funding to all provinces, regardless of size, as part of decentralization. An analysis by the author of total (all sectors including health) government budget allocations by province for 2010 shows that population size is not at all correlated with central government budget allocations to the provinces (see Figure 5). Ideally, central budget allocations to decentralized levels are used to promote equity by allocating more funds to poorer provinces. Key informants indicate that equity is not yet a criteria for MINFIN allocations to provinces.

FIGURE 5: POPULATION (LEFT AXIS) AND TOTAL PUBLIC BUDGET PER CAPITA IN USD (RIGHT AXIS) BY PROVINCE FOR 2010



Source: MINFIN 2009.

Note that total funds allocated to a province from MINFIN do not necessarily predict the level of funding for health, because the provincial governments have some autonomy to allocate among sectors. The IMF agreement of 30 percent for social sectors does not explicitly flow down to the provincial level, and in any case the 30 percent would include salaries that flow separately from MINFIN directly to the civil service payroll system.

4.2.4 PURCHASING

Purchasing of health services in Angola consists primarily of the government paying health worker salaries and buying goods and services, which is fragmented among different ministries and levels. The Ministry of Administration (MAPESS) pays all civil servants, including health workers, and this reportedly functions well – described as “semi-automatic”. Civil servants are paid regularly and the banking system used by MAPESS has relatively wide coverage. Non-salary recurrent costs include drugs, supplies, electricity, fuel, maintenance, cleaning, and so on, and are key to ensuring access to quality care. MINFIN allocates funds directly to national and provincial hospitals, and national institutes to cover these costs.

In the case of primary care (health posts and centers and district hospitals), these costs were covered by the provincial governments until 2007 when a new decentralization law designated districts as budgetary units (UO) with budgetary authority defined as the ability to spend funds autonomously, without seeking authorization from an overseeing

Box 3: Existing Financial Incentives

Health workers are part of the public civil service system. The base salary is a monthly amount (13 payments per year). There are five different subsidies that a health worker might receive, calculated as a percentage of the base salary: day shift 5 percent, night shift 7 percent, direct exposure to biological agents 7 percent, indirect exposure to biological agents 5 percent, isolated posting 5 percent, and posting in a rural area (“periferia”) 5 percent. In addition, there is additional salary per hour worked for overtime and additional duties. There are no incentives linked to performance measures such as productivity or quality.

institution. Since then, Angola has gradually been shifting budgetary control to the 164 districts: 16 in 2007, 54 in 2008, 70 in 2009, and with plans to reach 140 in 2010 (MINSA 2008).

A major challenge is the lack of management capacity at the district level. Hence MINSA's focus on the district level as described in their district health strategy (Governance section). To clarify, primary care facilities are "dependent entities" that do not have any budgetary authority. All operational resources are delivered in-kind (never cash) after the provincial or district authorities approve payment directly to the vendor to deliver the goods or services to the facility.

In the private sector and the secondary/tertiary levels of the public sector, patients pay fee-for-service. The insurance companies are reportedly also paying their contracted hospitals on a fee-for-service basis. There does not appear to be any types of strategic purchasing such as capitation, global budgeting, or pay-for-performance (also known as performance-based financing).

4.2.5 THE BUDGETARY PROCESS

Preparation of the General State Budget (OGE in Portuguese), led by MINFIN, begins in June and ends in September. The planning and budgeting process for investment runs in parallel with the operational budget and MINFIN issues a single consolidated document that presents the budget by specific categories defined by law (09/97) – institutional, functional, and economic. Unfortunately, none of these classifications allows for easy consolidation of total health spending, thus making a separate analysis necessary (Principia 2008).

TABLE 14: GOVERNMENT PLANNING AND BUDGETING CALENDAR

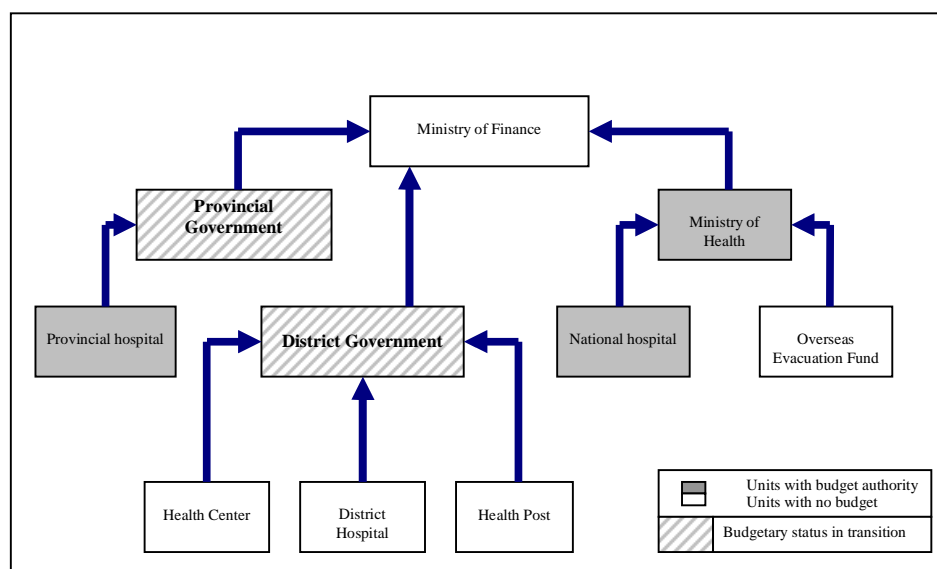
January to May	
1.	MINPLAN and MINFIN prepare macro-economic projections to estimate public revenues;
2.	MINPLAN and MINFIN define budget limits by province and sector (criteria unknown);
3.	MINFIN defines the programs in each sector based on limited engagement with sector staff. In 2006, GEPE, with assistance from the EU-PASS project, proposed a methodology for planning and budgeting the vertical health programs that are within MINSA. Key informants indicated that the new methodology is approved but not consistently used.
June to September	
1.	MINFIN releases instructions and forms to the UO to be submitted to the National Budget Direction (www.minfin.gv.ao);
2.	The UOs have 3 to 4 weeks to prepare budget proposals by program and for each Dependent Unit (OD) within their budget. For example, until 2008 the provincial government was the UO for all primary health expenditures and determined the proposed budget allocation for all district hospitals, centers and posts within its jurisdiction;
3.	UOs that already operate the national financial management system (SIGFE) on-line can submit their budget proposal via the internet.
4.	MINFIN adjusts the proposed budgets to be within the pre-defined limits, reportedly with limited negotiation with UOs.

MINSA oversees the budget proposal process for the national health programs, national hospitals and centers, and the Overseas Evacuation Fund. Until 2008, the provincial government, typically through the DPS, oversaw the budget proposals for all primary care facilities. The DPS did not have budget authority, but did exercise significant influence on how health funds were managed within the province (see next

section on the Budgetary Process for a list of functions). Now, depending on the progress of decentralization, this responsibility may reside with the district administration and the RMS, or continue with the DPS. GEPE has strived to improve the planning and budgeting process to be more evidence-based (epidemiological, utilization, and expenditure data from all provinces) and more programmatic (national health priorities). GEPE also tracks external assistance for national health programs, which is a significant contributor to the national programs.

Capital investments, which are often multi-year commitments, are more secure for construction projects already in process. Budget allocations reflect a negotiation among MINPLAN, MINFIN, GEPE, and the provincial governments.

FIGURE 6: STRUCTURE OF BUDGET DEPENDENCE SINCE 2008



Note: The arrows point from the dependant entity to the overseeing body. For instance, national hospitals rely on and must negotiate with MINSA for their budgets. Once they receive their budgets, those entities with budget authority may execute each line-item without seeking signatures from their respective overseeing body.

4.2.6 RESOURCE FLOWS AND MANAGEMENT

Figure 7 and 8 summarize the changes in the financial flows from the central level (mobilization) through financing agents (pooling and allocation) to the facilities (purchasing) under the new district regime. Donor funding is not captured in this depiction, as there are many donors operating at all different levels of the system. MINFIN allocates budgets to MINSA, national hospitals, provincial hospitals, and provincial governments, and participating district governments - all of whom have budgetary authority. The provincial or district governments in turn allocate funds to the primary care facilities.

The key non-salary recurrent costs covered by MINSA are essential drugs kits and human resource training. The essential drug kits, which consist of key drugs to support PHC and national health priorities, are transferred to health clinics, health posts, and some district hospitals. Human resource training is offered to all service delivery centers. As discussed in the Pharmaceutical and Human Resource sections below, drug procurement is irregular and human resource training is often an unfunded mandate.

The national health accounts exercise, which is being conducted by WHO and GEPE will show whether the new budget flows to the district administrators are really active and what they are funding.

FIGURE 7. HEALTH SYSTEM RESOURCE FLOWS IN 2005

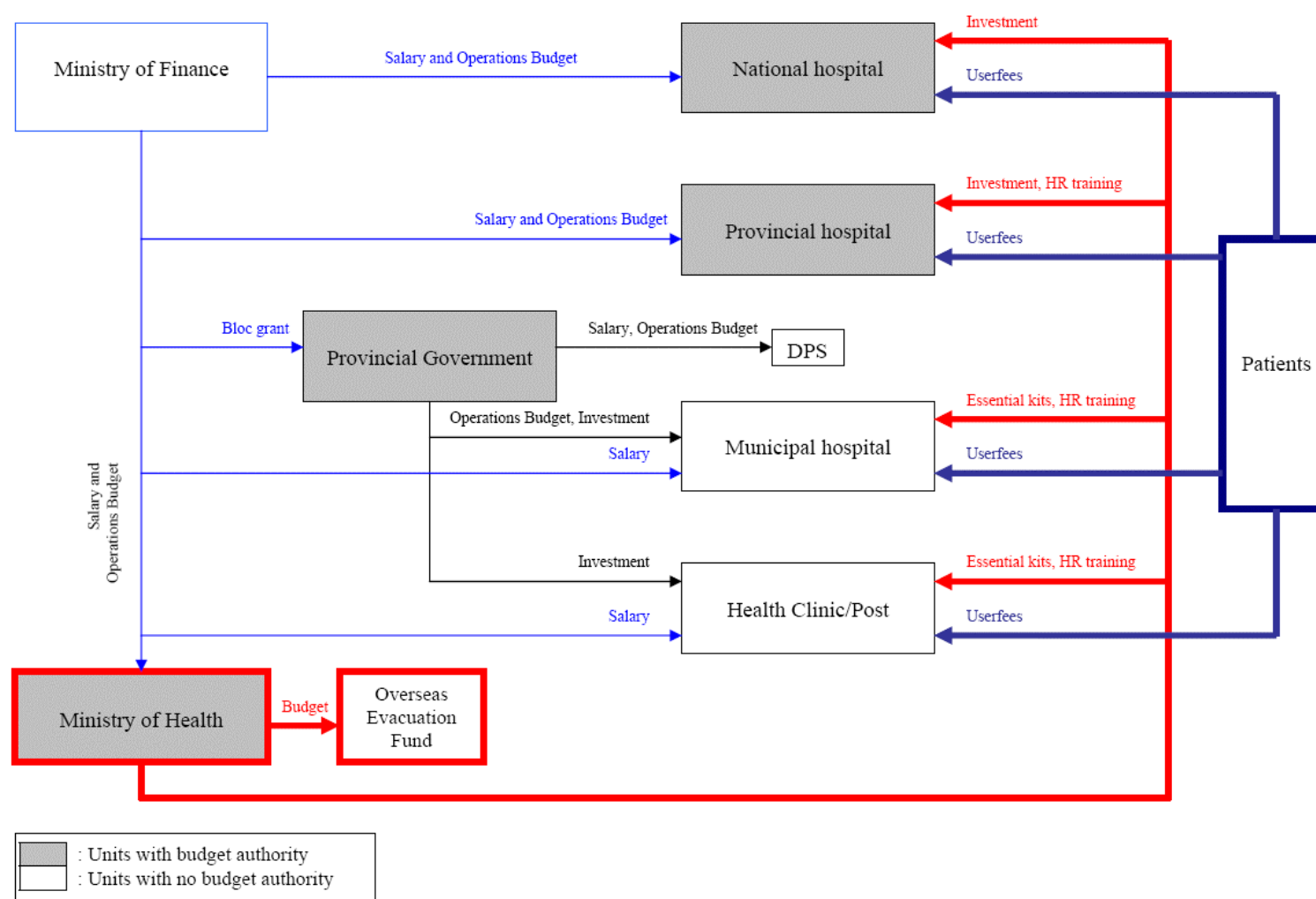
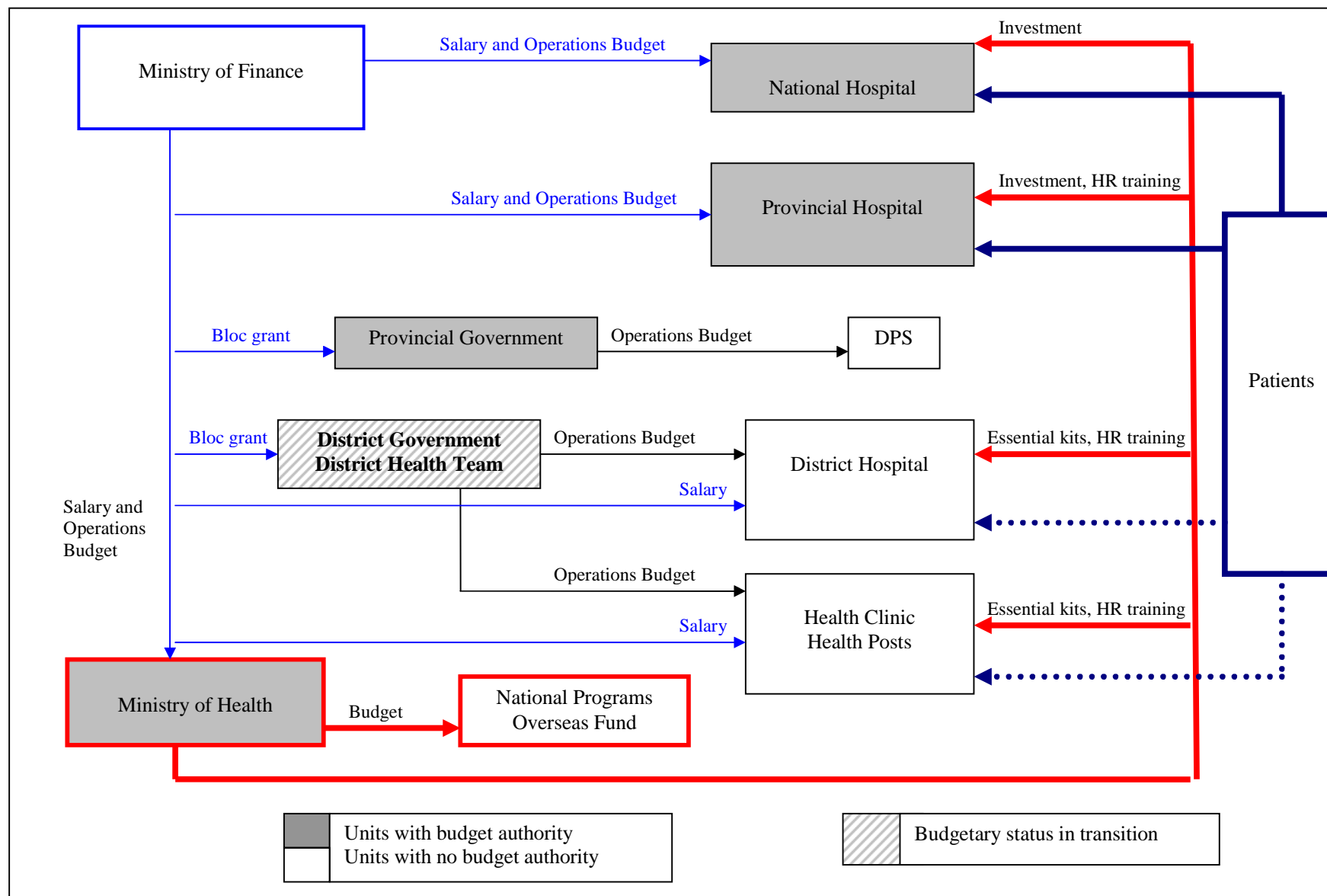


FIGURE 8: RESOURCES FLOWS SINCE 2008. NEW: DISTRICT GOVERNMENTS ELIGIBLE TO BE BUDGETARY UNITS AND USER FEES ELIMINATED AT MOST PRIMARY FACILITIES



Until 2007, the provincial health directorate (DPS in Portuguese) was responsible for programmatic and some financial management of primary health care. MINSA's district health strategy identifies the RMS as responsible for these and other functions including:

The District Health Teams should be responsible for the functioning of the district health system through planning and management, including integration of health and social programs in the district.

MINSA 2008

1. Prepare the district operational plan for health with district, provincial and regional health teams;
2. Ensure the integration of the district health strategy in the district budget and other financing sources;
3. Support the district health teams to offer the essential MCH service package through facilities and mobile units;
4. Provide logistical support to all levels;
5. Prepare monthly reports on district MCH activities, inventory of drugs and vaccines, and surveillance data;
6. Prepare a monthly supervision plan and make supervisory visits to guarantee delivery of quality services by primary care facilities and mobile teams.

The RMS reports to the district administrator, may be one person or a team, and may be employees that were formally known as the District Health Section or may be new staff, depending on the province.

The conversion of districts into budget units may increase the budget execution rate because UOs can spend funds autonomously, without seeking authorization from an overseeing institution. Historic data substantiate that budgetary units consistently spend more than ODs. However, the decentralization of budgeting and spending to the district level also has risks that link directly to governance issues:

- District capacity to plan and manage is weaker than the provincial level, which could lead to inefficiencies or even corruption;
- Advocacy for health funding will be more labor intensive as the responsibility shifts from 18 provinces to 164 districts.

TABLE 15: EXECUTION OF THE PUBLIC HEALTH BUDGET 2000–2005

	2000	2001	2002	2003	2004	2005
Budget	254.127	337.95	244.297	398.586	509.383	663.598
Spent	179.014	263.57	213.48	298.58	313.80	447.25
Execution %	70.4%	78%	87%	75%	62%	67%

Health budget execution averaged 73 percent from 2000 to 2005, the only years data are available. What constrains budget execution? Informants among the national health programs and primary care facilities perceive that disbursement of funds during the course of the year seems disconnected from the budget and planning process that happens almost a year earlier. Operating units are asked to justify

funding requests again, even though a budget was already approved. The request for more information to release funds is time consuming and delays activities. A separate problem is lack of autonomy and agility at the district level to deal with unanticipated needs. For example, if the ceiling in one health center is damaged by water and a subsequent bat infestation, but the repair cost was not anticipated in the district health budget. Facilities lack any cash, so even small spending decisions are made at higher levels. For example, a health post has no more liquid soap for cleaning floors, but received a package of bar soap for washing hands that it did not request. These examples illustrate the challenges to balance the efficiencies and responsiveness to be gained by moving money and control to the periphery versus the accountability required through proper controls on how funds are spent.

To track spending, the SIGFE is gradually being rolled out to all budgetary units. The IMF noted that the Government has "... recently decentralized budget execution to local governments, expanded the budget execution system, and for the first time produced the General Accounts of the state." The IMF recommended that these measures be complemented with internal controls, closer coordination of the current and capital budgets, and improvement of line ministry budgeting capacity (IMF 2009).

Up until 2007, all non-salary operating costs of primary health care⁷ were financed from the provincial government's global budget (a block grant from MINFIN). This led to wide variations in PHC spending per capita because the block grants are not based on consistent criteria (e.g., population size) and each province had autonomy to determine the allocation to health. For example in 2005, MINFIN allocated an additional US\$ 20 million to all provinces regardless of size, and in the same year Namibe allocated 30 percent to PHC and Cabinda only 10 percent. As noted earlier, provincial health spending varied widely from US\$ 5.7 per capita in Kwanza North to US\$ 34.7 in Namibe (see Figure 5 previous page). Public financing of PHC per capita could become more evidence-based and consistent based on the provincial health maps and development plans based on common norms for infrastructure and staffing (see Service Delivery section). However, in 2010 MINFIN apparently plans to allocate US\$ 5 million to each district, regardless of size.

⁷ Primary health care is defined as the services provided by municipal hospitals, health centers and health posts.

4.2.7 SUMMARY OF FINDINGS: FINANCING

This section summarizes performance of health financing in terms of the health system assessment criteria.

TABLE 16: PERFORMANCE OF HEALTH FINANCING IN TERMS OF HEALTH SYSTEM ASSESSMENT CRITERIA

	Equity	Access	Efficiency	Quality	Sustainability
Strengths and Opportunities	<p>District health strategy is being financed. Spending on primary health care grew 415 percent, faster than any other category since 2000 to capture 40 percent of the total by 2005. Informants believe that this trend continues.</p> <p>Public payroll system functions well. Health workers paid consistently, although certain cadres of health workers were not paid during the first quarter of 2010.</p>		<p>Information from Mapas Sanitários informs capital investments, and links capital and recurrent costs.</p> <p>Decentralization to district level could increase budget execution rates.</p>	<p>Public payroll system functions well. Health workers paid consistently.</p> <p>Need to improve distribution and capacity of work force.</p>	<p>Low dependence on external assistance.</p> <p>High GDP growth rate.</p> <p>Improvement in infrastructure (new health facilities, water, sanitation, and roads).</p>
Weaknesses and Threats	<p>Decentralization to the district level could limit the level of funds allocated to health and lead to financial barriers if patients must buy drugs and supplies in private sector.</p> <p>Decentralization a governance challenge to realize the expectation of greater citizen accountability in order to improve equity and access.</p>		<p>Need to advocate for allocation of funds to health will be more labor intensive as Angola shifts the responsibility from 18 provinces to 164 districts. District financial management is weak.</p>	<p>Central funding and procurement of essential drugs is inconsistent, leading to stock-outs and poor quality.</p>	<p>Disconnect between approved budget and actual spending can discredit the planning and budget process.</p>

4.3 HUMAN RESOURCES

All people engaged in actions whose primary intent is to enhance health are human resources for health, including public and private sector doctors, nurses, midwives, birth attendants, pharmacists, technicians and other paraprofessional personnel. Also included are managers, administrators, support staff, traditional healers, community health workers, and volunteers. Angola faces many of the same human resource issues plaguing the region – see table below.

TABLE 17: WHAT'S NEW SINCE 2005 IN HUMAN RESOURCES

2005	2010
<ul style="list-style-type: none"> 1. High number of nurses, but not trained for service level required; 2. Unequal distribution of health workers; 3. Shortage of doctors; 4. Lack of quality medical and health educational institutions; 5. Lack of supervision, quality assurance, and in-service training; 6. No health workers beyond health facilities. 	<ul style="list-style-type: none"> 1. Training needs and lack of skilled workers continue; 2. Unequal distribution continues, but more information available from Mapas Sanitários to accurately describe the problem; 3. Shortage continues although some improvements made: “importation” of doctors for short-term and new medical schools for medium-long term; 4. Five new universities, including medical and nursing schools, collaboration with foreign institutions; quality of pre-service training still an issue; 5. Supervision, quality and in-service training still lacking on large scale, but promising experiences exist; 6. Re-emergence of community health workers.

The 2005 HSA identified the lack of human and institutional capacity at all levels of the health system as a weakness, and the high quantity of nurses as a strength. In 2010, human resources emerged as one of the greatest constraints to the improvement of the Angola health system. While the overall number of health workers remains high, only a very small proportion is considered to be properly trained and skilled. The decades of war severely weakened the country’s capacity to produce a health workforce that is able to respond appropriately to the health needs of the population. As part of the peace negotiation process in 2002, the government absorbed approximately 9,000 people into the health workforce, many of which are basic-level *técnicos* (see definition in Section 4.4.5 below) and are still in need of training updates.

It appears that the monumental task of providing quality and continuous training and supervision to the existing health workforce still poses a challenge to converting the high number of health workers from an opportunity into a strength. This chapter describes in more detail specific aspects of human resources for health in Angola.

4.3.1 HUMAN RESOURCES DATA

The public health sector in Angola employs about 67,000⁸ people, of which approximately 38,000 are health personnel (non-administrative). Table 18 displays the number of doctors, nurses and *técnicos* in the public sector (see description of *técnicos* in section 4.4.5) by province in 2009. The number of doctors has more than tripled from 849 (Angola HSA 2005) in 2005 to 2,956. Trend data available from the MINSA (MINSA 2009) shows that the number of doctors in 2007 and 2008 was 1,525 and 1,899 respectively, signaling a steady and steep increase since 2005. The number of nurses also appears to have increased dramatically since 2005, from 16,037 (Angola HSA 2005) to 29,592. However, this marked variation is likely due to differences in the nurse classifications included in the statistics for 2005 versus 2009; especially considering that the number of nurses has not changed significantly since 2007: 28,848 in 2007 and 29,605 in 2008 (MINSA 2009). There was no data available in 2005 on the number of *técnicos*. The overall ratio of public sector health workers in Angola per 1,000 inhabitants is close to the WHO-recommended ratio of 2.28 health workers per 1,000 (WHO 2006). However, section 4.4.2 discusses the serious issue of their poor distribution within the country, which can already be observed by the high variation of health workers per 1,000 inhabitants at the province level in the following Table.

TABLE 18: HEALTH WORKERS IN THE PUBLIC HEALTH SECTOR IN ANGOLA BY PROVINCE

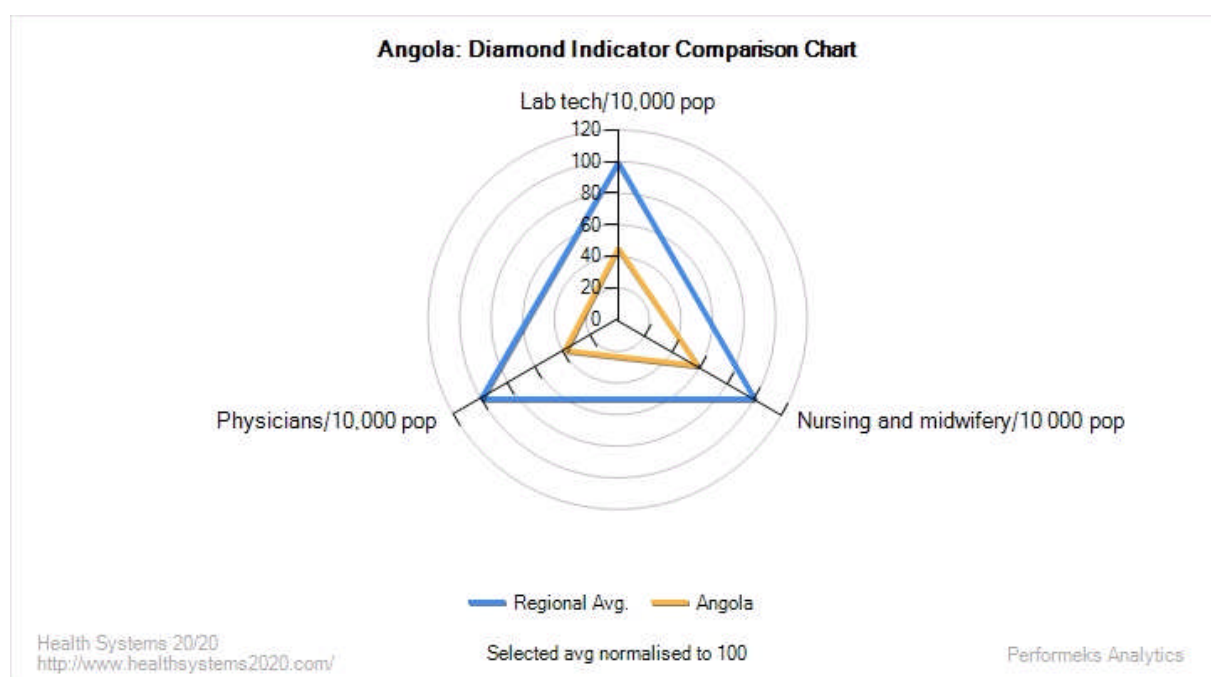
Province	Doctors ^a		Nurses		Técnicos		TOTAL	
	No.	No. Per 1,000 inhab	No.	No. Per 1,000 inhab	No.	No. Per 1,000 inhab	No.	No. Per 1,000 inhab
Bengo	87	0.41	954	4.49	99	0.47	1,140	5.36
Benguela	184	0.09	2,809	1.37	391	0.19	3,384	1.65
Bié	106	0.18	1,468	2.45	80	0.13	1,654	2.76
Cabinda	126	0.29	1,256	2.90	278	0.64	1,660	3.83
Cunene	103	0.28	922	2.51	73	0.20	1,098	2.99
Huambo	163	0.17	1,796	1.89	343	0.36	2,302	2.42
Huíla	187	0.10	2,052	1.11	495	0.27	2,734	1.48
K. Kubango	39	0.13	642	2.14	65	0.22	746	2.49
Kwanza Norte	115	0.46	1,051	4.20	88	0.35	1,254	5.02
Kwanza Sul	182	0.19	1,026	1.08	131	0.14	1,339	1.41
Luanda	982	0.22	8,750	1.97	2,590	0.58	12,322	2.78
Lunda Norte	94	0.16	839	1.40	89	0.15	1,022	1.70
Lunda Sul	87	0.33	753	2.90	67	0.26	907	3.49
Malange	147	0.33	1,146	2.55	82	0.18	1,375	3.06
Moxico	81	0.14	1,233	2.06	93	0.16	1,407	2.35
Namibe	103	0.56	941	5.13	257	1.40	1,301	7.10
Uíge	94	0.10	1,222	1.36	132	0.15	1,448	1.61
Zaire	76	0.38	732	3.66	82	0.41	890	4.45
TOTAL	2,956	0.17	29,592	1.74	5,435	0.32	37,983	2.24
a) Includes foreign doctors. Source: MINSA 2009.								

⁸ Interview with Human Resources Director at MINSA

There is no data on the number of private health providers in Angola. All doctors are required to register with the Angolan Medical Council (*Ordem dos Médicos de Angola*) and provide updated information on their place of practice, but this data is not available. The perception among key informants is that the number of qualified private health providers (doctors and nurses) is low and concentrated in the urban areas. District Profiles developed for a few districts reveal that in some remote areas that are underserved by health facilities the population reverts to private nurses, some of which are practicing without any formal training (Andulo District Profile 2007). Traditional birth attendants (TBAs) are also widespread with varying levels of training (Cabinda District Profile 2007).

Figure 9 compares the ratio of health workers in Angola with the regional average for Sub-Saharan Africa. According to this figure Angola is significantly below the average. The Mapas Sanitários show a different picture in terms of the size of the health workforce – an overabundance in the number of health workers, as was found in the 2005 HSA. This discrepancy may also be partially explained by the category of health worker included. The data for Figure 9 likely includes only intermediate-level nurses, while the Mapas Sanitários include all levels. The relative number of different health worker categories is discussed in more detail in the following section.

FIGURE 9. RATIO OF HEALTH WORKERS IN ANGOLA IN COMPARISON WITH SUB-SAHARAN AFRICA REGIONAL AVERAGE



In addition to nurses and doctors, the GOA has recently reintroduced the community health worker (CHWs) cadre (*agentes comunitários*), which existed as part of the health system until the early nineties when the civil war disrupted the health system. An estimated 6,000 CHWs have been trained in several separate initiatives by different organizations (MINSA, donors, NGOs).

4.3.2 DISTRIBUTION OF HEALTH CARE PROFESSIONALS

The uneven distribution of health care professionals in Angola, both geographically and by cadre, continues to be a problem. Rural areas are underserved in comparison with more urban ones. The data from the Mapas Sanitários illustrate this problem at the district level. Table 19 displays the number of districts in the provinces for which Mapas Sanitários were available (Benguela, Bié, Huambo, Huíla, and Luanda) that have a health-worker-to-population ratio within certain ranges. All health workers except for doctors are included in the ratio.

TABLE 19: NUMBER OF DISTRICTS BY PROVINCE WITH HEALTH-WORKER-TO-POPULATION RATIOS IN EACH RANGE

Province	Health Worker per 1,000 Population						TOTAL
	<0.5	0.5-1.0	1.1-1.5	1.6-2.0	2.1-2.5	>2.6	
Benguela	0	7	1	0	1	0	9
Bié	1	2	3	0	2	1	9
Huambo	0	2	1	1	2	5	11
Huíla	4	8	1	0	0	1	14
Luanda	0	5	2	1	0	1	9
TOTAL	5	24	8	2	5	8	52

Note: Converted from data in Mapas Sanitários: Benguela, Bié, Huambo, Huíla and Luanda.

Looking across all five provinces, most districts (24) have a ratio between 0.5 and 1.0 health workers per 1,000 population. Only 13 districts have a ratio that is near or above the WHO-recommended of 2.28 health workers per 1,000 (WHO Report 2006) (>2.1). The Huambo province is particularly well-served, with seven out of its 11 districts near or above 2.28; in the other extreme are Benguela and Huíla, with seven of nine and 12 of 14 of their districts respectively with less than 1.1 health workers per 1,000. The variation in health worker to population ratio among districts illustrates the issue of unequal health worker distribution in Angola.

Some of this variation can be explained by the presence of more types of health facilities in larger districts (such as referral facilities in addition to primary care health centers). However, according to key informants, the uneven distribution of health workers is an issue particularly at the health facility level, for which there is no reliable data. Anecdotally, while some health facilities are overstaffed, others are severely understaffed.

The main challenges cited by key informants to better health worker distribution were: lack of training institutions and therefore qualified personnel in more remote areas, and lack of infrastructure (transportation, residential quarters) or incentives to attract qualified personnel to these areas. In the Luanda province, the DPS has signed agreements with universities to provide scholarships to residents of more rural areas, who are then required to return to their districts when they finish their studies.

In addition to the geographic distribution problem, the distribution of different health worker cadres in Angola is far from optimal. Table 20 displays the proportion of health workers in five provinces that are doctors, intermediate level *técnicos* (including nurses) and basic level *técnicos* (see definitions in section 4.4.5). (The remainder of health workers fall under the “other” or “support” category.) In all five provinces the majority of health



This basic level técnico is the only staff member in a Health Post in a rural area of the Huambo province.

workers are of the basic *técnico* level, and a small proportion is of the intermediate *técnico* level. This presents a problem, since the skill and capacity at the basic *técnico* level is very limited. In fact, the goal of MINSA is to eventually eliminate this level by training the existing ones up to the intermediate level and offering only the intermediate level pre-service training. The country also faces a specific shortage of qualified nurse-midwives, who fall under the intermediate-level *técnico* category (MINSA 2009).

TABLE 20: PROPORTION OF HEALTH WORKERS IN KEY CATEGORIES IN FIVE PROVINCES

Province	Doctors	Intermediate	Basic
Benguela	<1%	21%	54%
Bié	<1%	18%	61%
Huambo	<1%	~25%	63%
Huíla	<1%	9%	58%
Luanda	3%	~25%	~50%

Source: Mapas Sanitários: Benguela, Bié, Huambo, Huíla and Luanda.

Table 20 also illustrates the severe shortage of doctors in Angola, with less than 1 percent of health workers in all provinces except Luanda constituting doctors. As a short term solution to the doctor shortage, the government has contracted or “imported” about 1,500 doctors mostly from Cuba for limited periods of time. It is also providing scholarships for Angolans to receive their medical education in Cuba. In the medium to long term, five new public universities have opened in Angola since 2005 (in the provinces of Malanje, Benguela, Cabinda, Huíla and Huambo), all of which include a medical school. The MINSA estimates that within four to five years these schools, in addition to a public and a private university in Luanda, will be producing 300 to 400 new doctors per year.

4.3.3 PRESENCE OF A HUMAN RESOURCES INFORMATION SYSTEM (WHO 2009)

The DPS collects health worker registration information from individual health facilities in a standardized paper-based form. The GEPE then compiles the information from all DPS into a national database that is updated yearly. This database includes the number of doctors and nurses. There is a question regarding the quality of this data, since the personnel in some health facilities do not possess the skills to collect this type of data. With the exception of doctors, who are tracked by the Angolan Medical Council, no other institution tracks private health workers.

In addition to the MINSA, there are other institutions in Angola that collect data related to human resources for health, such as: National Statistics Institute, Ministry of Defense, Medical Council, MAPESS), and Ministry of Finance. There is currently no coordination or data sharing among these institutions, and often the information from different data sources do not match. A recent assessment from the WHO illustrates this problem: “The Medical Council, MAPESS, and the Ministry of Finance track entries and exits of public health workers, however the Ministry of Labor perceived that their records do not capture all health professionals, for instance, professionals that are hired directly by the provincial governments or professionals hired by MINSA at central level such as foreign professionals or short term contracts. As the health system is decentralized at the provincial level, the Ministry of Health (MINSA) at central level does not have updated information on entries and exits of the health workforce” (WHO 2009).

The assessment cites two mechanisms that have been created to improve this:

- MINSA has a national coordination mechanism to develop, implement and monitor data on health workers; however, “it has very limited functional capacity”;
- In 2003 MAPESS began an initiative to digitize and systematize a public workforce information system. For the health workforce, the system was set up to receive “head count” information from MINSA and payroll information from the Ministry of Finance. However, the Ministries have not been able to report this information mostly due to capacity and infrastructure limitations (no internet connection or standardized database).

The WHO is working with MINSA to develop a Human Resources Development Plan that will include human resources information system.

4.3.4 HUMAN RESOURCES PLANNING

The last Human Resources Development Plan of MINSA expired in 2007. MINSA is currently in the process of developing a new plan with support from the WHO. The plan is to be accompanied by two-year operational plans.

The current process for allocating personnel to provinces, districts and health facilities reflects the need to develop a process that better matches the needs of facilities: although the REGUSAP describes the number and category of personnel required for each type of health facility, the “personnel table” (*quadro de pessoal*) is actually developed at the provincial level. This presents a problem when a health worker is transferred to a different facility or district within the same province. Because this shift is not reflected at the provincial level, the province cannot justify the hiring of additional staff to replace the loss at the health facility (MINSA 2009). This is likely a reason why staff requirements from the DPS to the central level are often unmet (see Section 4.4.7), and contributes to the issue of unequal health worker distribution.

It is recognized that the REGUSAP specifications for staffing health facilities is too rigid and theoretical and most often does not match the actual needs of the facilities. The Mapa Sanitário exercise currently underway is beginning to shed some light into the appropriate staffing needs of each health facility based on service and utilization data.

4.3.5 JOB CLASSIFICATION SYSTEM AND JOB DESCRIPTIONS

Public health workers fall under the “special health career” (*carreira especial em saúde*) track of public servants. There are four general classifications of public health workers:

- Doctors
- Nurses
 - Intermediate-level nurses (12th grade + 4 years of training), including nurse-midwives
 - Basic-level nurses (8th grade + 2 years of training)
- Diagnostic or therapeutic technicians (laboratory, pharmacy)

- Hospital support staff

The term *técnico* is often used to describe all of the cadres other than doctors. There is also a superior-level nurse cadre, which is when an intermediate-level nurse pursues additional training such as a bachelor degree. However, the number of superior-level nurses is very limited (the Mapas Sanitários recorded nine in Luanda, two in Huambo, one in Benguela, and zero in Bié and Huíla). One also finds that in most of the private pharmacies or chemical shops (*Posto de Venda de Medicamentos*) the person in charge is not a trained pharmacist, but what is called an “administrator” (*gestor*).

Public sector health workers are registered at MAPESS, along with all other public servants, under administrative categories that have no characterization of their professional duties or education (Mapas Sanitários, 2007). There are national decrees that describe the functions and requirements for each health worker classification. MINSA is in the process of reformulating the description of the nursing category (as mentioned above, the plan is to eliminate the basic level), and also plans to eventually update all others.

The newly reinstated CHW cadre has not been formally incorporated into the health system yet. In general, CHW tasks include home visits, community education and serving as a link to the health facility. However, although MINSA has held consultative meetings in the last two years on the topic of CHWs, it has not yet developed a clear policy that defines their specific role within the health system (responsibilities, whether they should be government employees, paid or volunteer, etc). As a result, the CHW programs currently in place represent an array of different models. In at least one province CHWs were paid about US\$ 50 per month with government funds through an NGO, however this payment has not been sustained. Other NGOs and donor programs are implementing volunteer CHW programs.

It will be key to ensure that enough incentives (monetary or not) are in place to make a CHW model sustainable. There are many examples worldwide of CHW models, ranging from fully public, salaried employees to volunteers, and to autonomous, private providers who sell health and other products to generate income (see Box 4). It would be of great benefit to all partners involved with CHWs in Angola to share experiences and lessons learned and coordinate to avoid duplication or interference. For example, in the Huambo province, one partner initiated a volunteer-based CHW program that relied on the Soba (the community leader) to select the CHW. Another partner launched a salary-based program nearby. After a few months, the salary payment was not sustained, and yet the CHWs from the volunteer program who had heard about the salary began to demand more incentives.

Box 4. Private CHW Models in Africa

Living Goods – Uganda

This model, launched in 2007, is a joint venture with BRAC, and combines microfinance with the community health worker concept. Village women are selected and trained to educate their communities on health promotion, sell health protection products door-to-door for a profit, and refer people to health facilities. Their first basket of products is obtained on credit, and the NGO provides close monitoring and supervision. For information visit: <http://www.livinggoods.org>

HealthKeepers – Ghana

A similar model to Living Goods. For more information visit: <http://healthkeepers-gh.org/>

4.3.6 COMPENSATION AND BENEFITS

Public health workers reportedly earn good salaries in comparison with other public servants and with private health providers. Their salaries are adjusted at least twice a year for inflation and in general are paid on time. There are also several subsidies provided, such as: overtime, night shifts, and occupational hazard (see Box 5). Compensation of public health workers was cited as a strong point of human resources.

The issue of incentives should also be examined in initiatives that add a significant amount of work or responsibility to the roles of an existing public sector worker, for example, the master trainer initiative or the integration training implemented by USAID projects in certain provinces and districts (see Service Delivery section 4.6.5).

Box 5: Existing Financial Incentives

Health workers are part of the public civil service system. The base salary is a monthly amount (13 payments per year). There are five different subsidies that a health worker might receive, calculated as a percentage of the base salary: day shift 5%, night shift 7%, direct exposure to biological agents 7%, indirect exposure to biological agents 5%, isolated posting 5%, and posting in a rural area (“*periferia*”) 5%. In addition, there is additional salary per hour worked for overtime and additional duties. There are no incentives linked to performance measures such as productivity or quality.

4.3.7 HIRING PROCESS AND LICENSING REQUIREMENTS

It is the responsibility of the provincial government to collect information from the districts on the human resources needs. The province then submits the request to the human resources department at the MINSA and to the MAPESS. This request must be accompanied by a justification. The MINSA verifies the request against its data set to confirm that there is a need, and the MAPESS forwards the request to the Ministry of Finance. Once the Ministry of Finance determines the financial resources available, it sends a notification to the MINSA of the actual number of approved vacancies (WHO 2009).

This number is almost always much lower than the original request, most probably due to two issues: budget constraints and lack of reliable data at the district and facility-level to justify the hiring of more staff (see Section 4.4.4). This process occurs once a year. Vacancies are posted at the provincial level, and the hiring process is the same for every public servant position: candidates need to pass an exam to get a position (*concurso público*).

All doctors need to be registered with the Angolan Medical Council, which accepts doctors licensed by Angolan medical schools and foreign medical schools that are formally recognized by the Council. Doctors must pay a monthly membership fee to the Medical Council, and if the fee goes unpaid for more than 12 months the council has the authority to remove the license (Charter of the Professional Association of Doctors in Angola). There is no Nursing Council yet, although MINSA has demonstrated an interest in creating this body. There are no national-level pharmacist or laboratory technician associations. In the Huambo province there is a pharmacist association, AFAPOS, which is recognized by the DPS and inspects and approves all pharmacies. AFAPOS is collaborating with a PMI project with private pharmacies in Huambo (see Pharma and Service Delivery sections). There are no re-licensing or continuing education requirements for health personnel.

4.3.8 HEALTH WORKER TRAINING AND SUPERVISION

The following training functions for health workers fall under the domain of MINSA:

- Pre-service training for intermediate levels (does not include doctors)
- Medical residency
- Graduate studies (*pós-graduação*)
- In-service training

Medical schools are under the domain of the Ministry of Education. The pre-service training capacity in Angola is still very limited. Until very recently there were only two medical schools in the country, one public and one private (both in Luanda). As mentioned above, it is hoped that the opening of five new medical schools will increase the output of new doctors. The new universities also bring a much-needed addition to the one existing intermediate-level nursing school and limited number of training institutions for *técnicos* in general. There are still no training schools for laboratory technicians; the existing technicians are nurses that received limited laboratory training. Although the addition of new universities is an important improvement, the quality of the programs is still a problem. Teaching capacity and existing curricula are very weak, and lack of resources for materials and teaching aides presents a barrier to quality training. Angola does have agreements of collaboration with health and clinical teaching institutions from Brazil, Cuba and Portugal, but their scale and impact is not clear.

In-service training is particularly important in the Angolan context: a significant number of the workers absorbed into the health workforce as part of the peace process had no training, but are still functioning as *técnicos*. Major efforts are needed to provide in-service training to these workers to bring them up to the basic and intermediate levels necessary for a minimum quality standard of services. This is in addition to the need to routinely update all health workers with continuing education.

A few DPS have a continuing education unit that is responsible for organizing training (*núcleo de formação permanente*). Most of the time the in-service training consists of short courses or workshops organized by the MINSA's vertical programs (reproductive health, HIV/AIDS, etc.) (MINSA/PASS 2008). However, these appear to be infrequent and to cover a very limited number of staff, except where donor assistance is present. The Integrated Management of Childhood Illnesses (IMCI) trainings carried out by donors up until 2005 have not been institutionalized within MINSA and therefore have not continued. More recently a USAID-funded project is training health facility staff in select districts as master trainers, who are responsible for the continuing education of the staff in their health facility (one master trainer per health facility).

Some key informants suggested that MINSA could be making better use of the “imported” doctors it hires by involving them in training and mentoring, in addition to providing clinical services.

Supervision at the facility level is also a duty of the DPS. Supervisory visits are supposed to happen monthly or every two months, but due to resource limitations for transportation, are rarely done. Some vertical programs, especially those with donor support, are able to carry out supervisory visits with more frequency. In 2005 MINSA already recognized the need to integrate supervision across vertical programs, but this intention has not materialized. The USAID-funded projects are implementing supervision activities in select provinces, such as: developing and posting job descriptions at the facility;

adapting and implementing a supervision tool; and funding supervisors for select districts who are able to carry out regular supervision visits to the health facilities.

4.3.9 SUMMARY OF FINDINGS: HUMAN RESOURCES

This section summarizes performance of the human resources for health in terms of the health system assessment criteria.

TABLE 21: PERFORMANCE OF HUMAN RESOURCES FOR HEALTH IN TERMS OF THE HEALTH SYSTEM ASSESSMENT CRITERIA

	Equity	Access	Efficiency	Quality	Sustainability
Strengths and Opportunities	Decentralization and revitalization process can potentially shift human resources allocation responsibility down to the district level, allowing for more equitable staffing at facility level.	“Imported” doctors: reasonable short-term solution to doctor shortage.	New information emerging from Mapas Sanitários will enable better human resources planning.	New universities and medical schools. Imported doctors can also be used for capacity building, in addition to service delivery.	Health worker compensation is competitive and paid on time. Health worker dedication is notable at all levels of the system.
	Reintroduction of CHWs can strengthen the link between communities and health facilities. Promising experiences in select provinces and districts (master trainers, supervisors, CHW models, agreement with universities to train residents from remote areas).				
Weaknesses and Threats	Poor distribution of health workers.	Low number of qualified health workers (intermediate level and higher).	Lack of updated and reliable human resources information system. No mechanism for evaluating, sharing and coordinating experiences and pilots, such as CHW models.	Low skill level of health workforce. Weak pre-service and in-service training. Lack of capacity and resources for supervision.	Incentives must be in place for new health worker cadres (CHWs) or added responsibilities.

4.4 MEDICAL PRODUCTS MANAGEMENT

Medical products encompass medicines, vaccines, test kits, related commodities and equipment. They are a core component for health services because their monetary value is generally substantial and the systems for managing these products are often faced with political and managerial challenges. The current public sector system has been evolving over the past five years yet there continue to be significant system failures that result in frequent and prolonged stock-outs and losses. MINSA has asserted its commitment to improving access to essential medicines and medical products through the approval of the National Medicines Policy and of a new procurement and distribution mechanism. This section describes the current management system and key performance issues. Nonetheless, ensuring access to safe, quality and affordable medicines and other medical products to the population remains a serious challenge in Angola.

TABLE 22: WHAT'S NEW SINCE 2005 IN MEDICAL PRODUCTS

2005	2010
<ul style="list-style-type: none"> • Draft National Medicines Policy; National Essential Medicines List and National Formulary; • Irregularities with centralized procurement for essential medicines kits; • Frequent stock-outs; • Revision of tools to support inventory control (e.g. stock cards, requisition forms); • Lack of information on provincial level medicines expenditures and management; irregular implementation of co-payment (“<i>comparticipação</i>”); • Lack of a functional quality assurance system for products and use. 	<ul style="list-style-type: none"> • National Medicines Policy is approved; • Sector strategy presented identifying the creation of regulations and agencies for implementing them; • Irregularities with centralized procurements; • Stock-outs; poor estimates of quality needs; • Roll out of use of new inventory management forms; use of forms to support group and local purchases; • Few improvements in storage conditions; • Co-payment practices suspended; • Components of a quality assurance system defined but not functional.

4.4.1 OVERVIEW

The National Directorate of Medicines and Medical Supplies (Direcção Nacional de Medicamentos e Equipamentos – DNME) is responsible for developing the strategic planning and implementation of norms regarding the production, importation, procurement, use and maintenance of all appropriate technologies, including medicines, diagnostics, surgical supplies, and other medical commodities. This includes activities that impact on both the public and private sectors, and the relationship between them.

The priorities for medical products for MINSA are defined in the National Medicines Policy. The policy was updated and approved in March, 2010. It defines the roles and responsibilities of various agencies and organizations with respect to implementing the policy and provides the legal basis for them to act in support of the goal of access to safe medicines of assured quality at affordable prices to the population. The structure for the DNME is presented in Box 6. Many of these structures, such as the Section for Product Registration and the National drug Quality Control Laboratory (LNCQ) are not yet supported by appropriate regulations so are not currently functional. In the case of the LNCQ, it is not yet equipped, nor staffed.

Box 6: Structure of the National Directorate of Medicines and Medical Supplies

Department of Medicines and Health Products

Department of Medical Equipment

Department of Pharmacovigilance and Traditional Medicines

Department of Diagnostics

Section for Product Registration

Quality Management Service

National Essential Medicines Program (PNME)

National Drug Quality Control Laboratory (LNCQ)

Central Procurement and Distribution Services (*Central de Compras e Aproveitamento* – CCA)

The DNME receives technical assistance from the national drug authorities of Portugal and Spain, and from the Oswaldo Cruz Foundation (FIOCRUZ) of Brazil, as well as from WHO and USAID. For example, INFARMED, the national authority for Portugal is supporting training in drug quality evaluation, and WHO has supported training of the staff of the Product Registration Sector. The National Essential Drugs Program (PNME) received technical assistance from the EU to update and publish the guidelines for the management of inventory. USAID, through the PMI and the bilateral program SES, has supported the dissemination of these materials and training of provincial warehouse managers and supervisors.

The management of medical products within the public system reflects the way that budgets are allocated. Some functions are centralized, such as procurement of essential medicines and kits, and others are decentralized to various levels of the health system. Provincial health authorities are responsible for managing their budgets to ensure the availability of medicines in their hospitals. Medical products required for vertical programs supported by donors are managed separately by the donor agencies.

An important development in the last five years is a commitment to strengthening of the quality assurance system by creating a medicines registration program, the drug quality control lab, and the pharma-covigilance program. In addition, in 2007, a law was passed requiring all provinces to establish a Provincial Drug Regulatory Authority responsible for enforcing national regulations including registration and licensing. As with other elements of the DNME, the process of developing capacity to carry out this mandate, including the supporting regulations and legislation, is underway. The design of systems and procedures to support implementation of these mechanisms and enforcement of regulations the still need to be defined and a cadre of qualified staff will be needed to implement them. For this, MINSA/DNME is receiving some support from international partners and donors. The significance of this development for the medical products component is the opportunity to consider a viable role for the private sector to support the public sector goals to increase access to affordable quality medicines in a more meaningful way than contemplated five years ago.

4.4.2 MANAGING SELECTION

The DNME is directly responsible for managing the National Formulary and the selection of medicines to be procured with public funds. This National Formulary is a list of all medicines approved to circulate in the country. The current list is considered to be obsolete by the DNME because it is outdated and that it cannot be supported by a registration system and corresponding controls. From this list, MINSA has extracted a short list of essential medicines - National Essential Medicines List (NEML) - that is also developed and managed by the DNME. This list, last revised in 2006, was developed following WHO

guidelines that specify consideration of such criteria as relevance for national public health priorities, use of international non-proprietary names, and costs. The selection process results in a “shopping list” that MINSA considers priority items for their facilities.

There are three sub-lists that correspond to the contents of kits of essential medicines and a limited selection of commodities that are distributed to all MINSA health posts, and health centers (those with doctors and those without). In Angola, there are three different kits: health post kits, health clinic kits, and complementary kits for district hospitals that staff physicians. In principle, to keep the list up to date with advances in medicine and technology, the DNME is responsible for forming and leading a technical committee to regularly review this lists and to evaluate proposals for the addition or deletion of items from the list. Changes in national treatment protocols or policies often drive the process. For example, in 2006 artemether-lumefantrine was added to the list and chloroquine was eliminated due to a change in malaria treatment policy. This list now needs to be reviewed and updated against the recommendations for services defined in the basic package of services, which identifies the services to be offered at the primary care level, and the corresponding treatment protocols. It should be noted that in principle rapid diagnostic test kits and other laboratory supplies are also the responsibility of the DNME although many are managed exclusively through vertical programs.

4.4.3 PROCUREMENT

According to the DNME, the budget from the General State Budget (OGE) for 2010 for the procurement of medical products was US\$ 121.4 million or about 7 percent of the total MINSA budget. This budget, which is generally considered to be inadequate to meet the need, has been cut each of the last three years. The central budget is used to procure the kits directly while each budgetary unit receives an allocation that can be used to support the procurement of medical products. International donors procure the supply of medical products for the programs they support: UNFPA procures reproductive health kits and contraceptives, and USAID procures Artemisin-based Combination Therapies (ACTs). UNICEF and WHO procure Anti-Retro Virals (ARVs), mosquito nets and vaccines through the Global Fund mechanisms.

The procurement of kits and other essential products through the PNME are conducted following international competitive open tenders on an annual basis consistent with national procurement laws. The decentralization of financing to the provincial and lower levels has not been uniform across all the provinces and generally left to the discretion of the provincial authorities, and is reflected in the way that budgets are executed. Some provinces (e.g. Huambo) engage in “*compras agrupadas*” in which the DPS compiles the needs from the facilities and submits them to DNME to supply. For smaller purchases as these “*compras locais*”, the appropriate mechanism is by requesting quotes from at least three licensed suppliers.⁹ According to the DNME, an on-line e-procurement system is being considered to support procurement at the provincial and district levels. Health facilities designated as budgetary units are able to purchase medicines to supplement the supplies received from the central level. These procurements still must follow government procurement laws that stipulate the appropriate procurement method according to the value of the procurement.

Data from the provincial health maps are allowing for a more complete understanding of expenditures on medicines than was available in the past. Expenditure patterns are beginning to emerge. For example, Table 22 below presents the summarized findings for five provinces for which data was available at the time of preparing this report. These results illustrate the variation in practices between provinces. In

⁹ According to the DNME there are approximately 350 wholesalers licensed to import medicines.

Huila province, with the exception of one municipality, the health facilities did not make any purchases but the DPS did as a measure to supplement kit supplies. As can be expected given the types and volume of medical products used in hospitals, these purchases account for the bulk of purchases. In Benguela there is a different pattern that indicates a greater proportion of expenditures for the health post and center levels than the hospital level, and accordingly the per capita expenditure is comparatively lower than the other provinces.

TABLE 23: VALUE OF EXPENDITURES ON MEDICINES 2005-2006 FOR SELECT PROVINCES

Expenditure Indicators	Huíla	Benguela	Bié	Luanda	Huambo
Total value of expenditures USD (000)	\$1,973	\$1,574	\$885	\$8,833	\$1,7587
Value of kits as % of total expenditures	22%	9%	23%	3%	20%
Local purchases (excluding hospitals) as % of total expenditure	6%	54%	18%	24%	26%
Purchases by hospitals as % of total	72%	37%	59%	73%	54%
Per capita expenditure (including hospital expenditures)	1.32	0.58	0.76	1.89	1.35

Source: MINSA/GEPE. Mapa Sanitários, 2007.

While information is more readily available about the value of purchases, and the contents of the various types of kits is standardized, information about what medical products (medicines and supplies) outside of these were purchased is not readily available. Requisition forms that would indicate the types and amounts of medicines requested by the facilities are being used to some greater and lesser degrees in the provinces and districts and should be used to analyze how expenditures are used (e.g., the fastest moving and highest value items by therapeutic classification).

Breakdowns in the procurement process were frequently mentioned and can be traced to three issues: 1) the lack of population and services utilization data; 2) limited capacity to manage inventory; and 3) a lack of a predictable budget.

Data Needs: In principle, procurements are based on needs estimations that filter up from the lowest levels through the DPS where they are compiled and forwarded to MINSA/DNME where they are used to prepare the tender documents. Needs estimates for essential medicines kits are made on the basis of population size, expected utilization rates and past consumption, which are then adjusted to the availability of a budget. For essential medicines kits, health posts, health centers, and district hospitals that staff physicians are allocated one kit for every 1,000 consultations per month. This estimate is based on average expected consultations over the course of a year. On a month-to-month basis, some facilities can actually conduct more than 1,000 consultations per month. Having accurate monthly consumption information over a period of time is needed to be able to predict with some accuracy expected needs.

Capacity Needs: The lack of staff capacity to provide information has had an impact on data consumption, which has been flawed. In addition to staff not knowing how to calculate needs, in many cases the very forms required to track consumption in the facilities have not been available. Calculations of past consumption that do not take into consideration periods of stock-out contribute to erroneous need-based estimates. With the reintroduction of inventory record keeping systems and patient records, along with better information about the population base, needs estimations based on past consumption should improve. Inaccurate needs estimates can come from both the very nature of the kit system as well as from not following proper inventory management practices to correctly document consumption. Consumption estimates are also influenced by local purchases that occur to “fill gaps”.

Budget Constraints: The greatest challenge to the procurement process is not only an insufficient budget, but it also related to budget execution. The DNME is responsible for reconciling needs against an expected budget, and to seek support from donors as needed to fill gaps. Due to weaknesses in the national budget execution process, breakdowns have occurred during the tender because the expected budget was not available when needed. This has had disastrous implications not only because the procurement shuts down, but also because reputable international suppliers lose confidence in the government's ability to meet its contractual responsibilities. Many suppliers opt not to compete for fear of the possibility of a breakdown or bid higher, less competitive prices knowing that there will likely be few competitors.¹⁰ At the time of writing this report, MINSA was hoping to resolve a procurement breakdown that resulted in stock-outs of kits since October 2009. The kits were supposed to be delivered in May 2010.

In recognition of the serious issues with the public procurement system, MINSA announced in 2009 the intent to release the DNME from this responsibility and to create a semi-autonomous Medicines Procurement Agency (*Central de Medicamentos*). The rationale behind this is that this new entity will be not only be properly equipped and supported to conduct complicated and large procurements, but it will also have the incentives to perform its duty efficiently. Although the details for this entity have yet to be finalized, it is not clear at this point how the problem of fiscal weaknesses will be addressed.

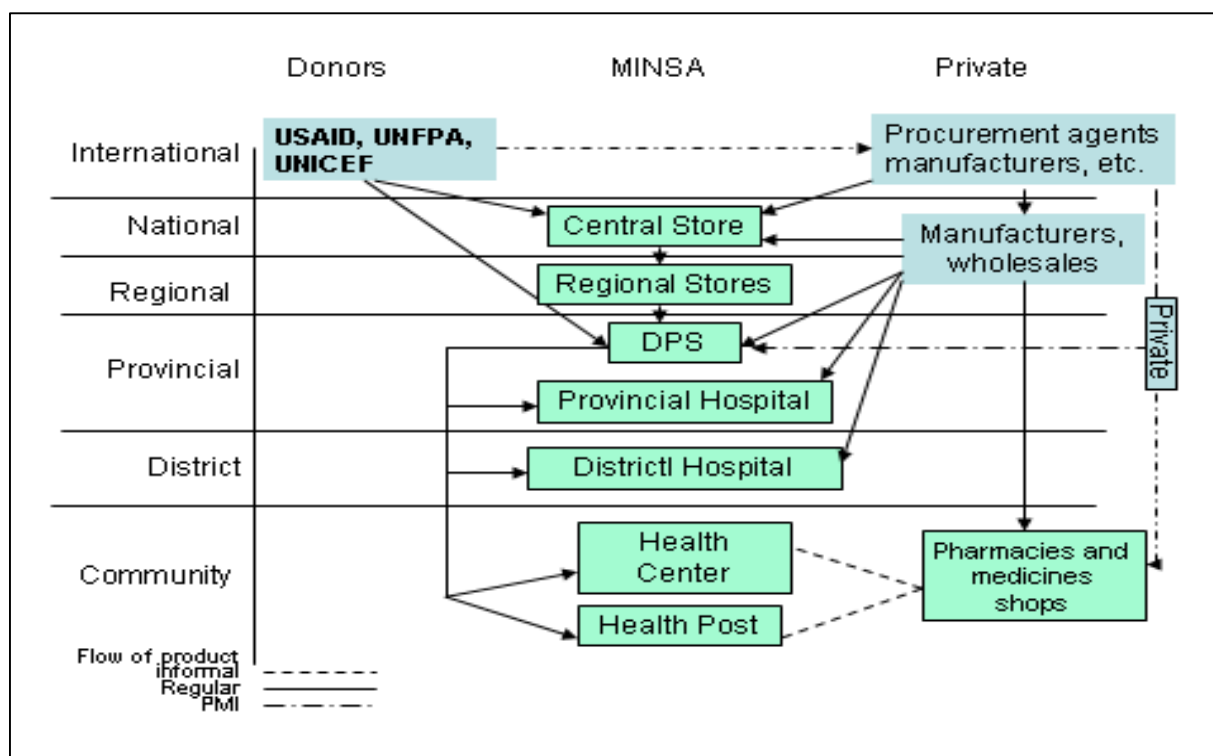
There is a general belief that is being increasingly substantiated by data that private or out-of-pocket expenditures for medicines are significant in Angola. Although basic services, including medicines, are intended to be provided free of charge to the population, shortages can oblige providers to instruct patients to purchase their needs in the private sector. Estimates derived from the provincial health profiles indicate that as much as from one-third to one half of all patients that should have received a medicine did not. In 2005, some facilities were noted as purchasing medicines from local pharmacies and selling them to their patients, and some were selling the supplies they received from MINSA. The act of selling, called “comparticipação”, allowed facilities to use the proceeds to meet otherwise unmet needs. In 2006, although the practice of charging fees for service, including medicines, is not illegal, the practice was suspended as no regulation or standard had been established to guide the practice and to ensure that basic services would not become inaccessible to patients.

4.4.4 STORAGE, DISTRIBUTION, AND LOGISTICS

The DNME operates two distribution systems. Standardized kits are “pushed” to health centers and health posts on a pre-determined (monthly) schedule. Kit systems are considered to be appropriate for very weak health systems that do not have the capacity to manage a traditional supply chain with needs-based requisitions of individual products. The traditional “pull” system works with a full complement of medicines and is used to support the needs of the higher level health centers and hospitals. In this system, facilities prepare requests for specific items and quantities based on estimates using past consumption.

¹⁰ Prices obtained through tenders in 2009 were not available for review.

FIGURE 10: FLOW OF MEDICAL PRODUCTS IN ANGOLA



For medicines procured and imported by MINSA, including kits, the most recent tender documents call for “delivery duty paid” procurement, to the main warehouses of Angola. Angola currently has three major regional medical stores (warehouses) located in Luanda, Benguela, and Namibe. The store in Luanda is owned by the state-owned manufacturing plant *Angomedica*, renovated with support from UNFPA, that serves as a central medical store and is used to support the distribution of reproductive health products procured by UNFPA. USAID/PMI also used this warehouse to support the distribution of its products until 2009, after there was significant theft of supplies. This theft served to highlight the value of a reliable inventory management system. A system was put in place in the central medical store with support from USAID/PMI in 2008/9 but although useful for detecting the theft of ACTs, it is no longer in use¹¹ and the lack of confidence in the warehousing and, by association, transportation capacity of MINSA has prompted vertical programs to contract services from the private sector at considerable costs.

In general, these warehouses are considered to be inadequate in terms of size and condition and the OGE for 2010 indicates that three new regional stores will be built in the coming years. One will be built in the Lubango and will cover the provinces in the south (Huila, Namibe, Cunene, and Kunado Kubango). Another will be based in Lobito to cover Benguela, Kwanza Sul, Huambo e Bié provinces. A third store will be built in Malange to cover Lunda Norte, Nuanda Sul and Moxico provinces. A new store in Luanda will cover the provinces of Kwabza Norte, Uige, Bengo, Zaire and Cabinda. Until these new warehouses are built, and until demonstrated otherwise, medical stores security will continue to be a serious concern.

¹¹ According to USAID, the Oracle based system is no longer in use because the license is not being paid for by MINSA for reasons unknown.

The procurement schedule specifies delivery from the suppliers or the central medical store to the regional stores twice per year only. Each regional store has an employee who is responsible for arranging the transport of medicines and supplies to each province within its domain. This employee receives his terms of reference from MINSA (as a federal employee), but is selected by the authority of the province in which that regional store is located. Since all planning is done by MINSA, the store employee is only responsible for ensuring that the said amount of kits arrives to their respective provincial stores. This individual is not responsible for any planning.

Once the six months worth of supplies arrives at the designated store, they are parceled out and transported to each of the 18 provinces on a monthly basis in response to requisitions received from the DPS. Although the DNME does have some vehicles, most of the transportation to the provincial level is contracted to private companies. Distribution to the districts and lower levels is on a pick-up basis managed by the local level authorities. In Huambo, the team observed that the DPS managed a monthly schedule, which indicates the dates when facilities assigned to specific groups can expect to submit requisitions, and pick them up (see photo below). In principle, the costs and logistics of all drug distribution, from the regional to the health clinic level, is the responsibility of MINSA. The lack of resources from MINSA has forced provincial governments to manage the distribution to the facilities using their own resources.

Storage conditions in the stores, hospitals, health centers and posts alike are generally sub-optimal and many are considered inadequate in terms of size and condition.¹² Such conditions imply lack of control over the supply itself as well as ability to manage the quality of the product, especially for products requiring temperature control.

The provincial health maps identify new construction, renovation, and equipment needs (e.g., cold storage) for warehouses and health facilities, including storage. Presumably, provincial and district level authorities will be able to use this information as to develop their annual plans.

Mes: Fevereiro 2010							
	Grupo I	Grupo II	Grupo III	Grupo IV	Grupo V	Grupo VI	Grupo VII
REVISÃO DE PEDIDOS	1	3	8	10	12	16	18
DESPACHO	2	5	9	11	15	17	19
TRANSPORTAÇÃO	3	8	10	12	16	18	22

Mes: Março 2010							
	Grupo I	Grupo II	Grupo III	Grupo IV	Grupo V	Grupo VI	Grupo VII
REVISÃO DE PEDIDOS	1	4	9	11	15	17	19
DESPACHO	3	5	10	12	16	18	22
TRANSPORTAÇÃO	4	9	11	15	17	19	23

Mes: Abril 2010							
	Grupo I	Grupo II	Grupo III	Grupo IV	Grupo V	Grupo VI	Grupo VII
REVISÃO DE PEDIDOS	1	5	8	12	14	16	20
DESPACHO	2	6	9	13	15	19	21
TRANSPORTAÇÃO	5	8	12	14	16	20	22

Mes: Maio 2010							
	Grupo I	Grupo II	Grupo III	Grupo IV	Grupo V	Grupo VI	Grupo VII
REVISÃO DE PEDIDOS	3	5	7	11	13	17	19
DESPACHO	4	6	10	12	14	18	20
TRANSPORTAÇÃO	5	7	11	13	17	19	21

Monthly schedule of when facilities submit requisitions and pick up deliveries. Photo by Maria Miralles.

Currently, there is no unified and integrated information system to track the flow of supplies from the warehouses to facilities through the various levels. The DNME has identified this as a serious shortcoming that places an additional burden on monitoring and supervision of the activities at these facilities. The ability to ensure reliable supervision of the supply chain is a constant challenge for MINSA due to the burden of competing demands on a limited number of qualified staff. This includes staff needed to monitor activities for the various vertical programs. Since 2005, personnel from each of the provinces have received training (including refresher training) on conducting supportive supervision on inventory management with support from USAID and other donors. Opportunities for harmonizing and

¹² Data on the value of losses due to theft from the various warehouses were not available.

streamlining monitoring and supervision amongst the various programs are being explored amongst the donors and MINSA at the time of preparing this report.

4.4.5 RATIONAL USE

At the foundation of good selection and estimation exercises that impact on procurement is a set of assumptions and expectations about how the medicines will be used. Appropriate prescribing and use by patients are important aspects of an effective supply system.

In order to support appropriate prescribing, MINSA together with support from its partners has developed several standard treatment guidelines and protocols. They indicate the preferred line of treatment for common conditions which, in principle, have been shared with and accepted by the DNME for inclusion into the essential medicines list. Treatment guidelines should be updated regularly and widely disseminated, yet some are not updated, not yet completed or sanctioned, and others are not yet widely disseminated. Dissemination generally includes training. According to the 2007 MINSA/WHO study (Table 24), only half of the facilities surveyed had any treatment guidelines available at the time the survey was conducted. Twenty percent of the prescriptions were for brand name products that patients have to purchase in the private sector. Contrary to good dispensing practices, only seven percent of the dispensed medicines were properly labeled and a mere five percent of patients that were interviewed could correctly explain how they should take their medicines.

TABLE 24: RATIONAL USE INDICATORS (MINSA/WHO 2007)

% of prescribed medicines that:	
Are on the Essential Medicines List	72.2
Are prescribed using the brand name	20.5
Are correctly labeled	7.0
% health facilities with standard treatment guidelines (malaria, sexually transmitted diseases and child health) and the national formulary	53.0
% of patients who know how to take their medicines	5.3

A facility-based system for the regular review of prescription practices and outcomes does not currently exist, although the DNME had included the establishment of facility-based pharmacy and therapeutics committees in its strategic plan.

4.4.6 SUMMARY OF FINDINGS: MEDICAL PRODUCTS

This section summarizes performance of the medical products system in terms of the health system assessment criteria.

ACCESS

Prior to the existence of the provincial health maps, there was no comprehensive inventory documenting the geographic location of health facilities relative to the populations they are intended to serve. Although this information is still being compiled, it is generally recognized that the distribution of health facilities, and by association the medicines they should be stocking, could be improved to better reach some of the more remote areas of the country. The existence of private sector pharmacies and drug shops increases geographic access to medicines in general, although they may not be the products used in public facilities, or be of assured quality, and are not available free of charge.

Following on from the issue of geographic access to dispensing facilities is the question of whether or not these facilities are stocked. Shortages can be traced through the supply chain. At the time of writing this report, the kit system in Angola was experiencing its seventh month in stock-out due to a breakdown in the procurement process, impacting all facilities throughout the country. According to a study conducted by MINSA with support from WHO in 2007 (Pharmaceutical Sector Survey 2007), only half of the provincial warehouses had on hand the full selection of essential medicines at the time of the survey, and none of the health facilities surveyed had the full package of essential medicines on hand. Findings from five provincial surveys presented in Tables 25 and 26 below reveal severe and widespread shortages of basic medicines and equipment in health facilities.

TABLE 25: AVAILABILITY OF ESSENTIAL SUPPLIES IN HEALTH UNITS

Percentage of Health Units with Selected Medicines				
Location	Magnesium Sulfate	Oxytocin	Hydralazine Hydrochloride	Lactated Ringer's Solution
Bengo	28	39	17	89
Lunda Norte	45	36	0	64
Malange	31	23	0	100
Moxico	30	25	10	60
Uige	24	20	20	96

Source: Mapas Sanitarios.

TABLE 26: AVAILABILITY OF ESSENTIAL EQUIPMENT IN HEALTH UNITS

Percentage of Health Units with Selected Equipment								
Location	Bi-Auricular Stethoscope	Oxygen Tank	Delivery Kit	Foley Catheter	Curettage Kit	C-Section Kit	Forceps Kit	Suction Kit
Bengo	56	16	28	33	17	6	6	6
Lunda Norte	93	9	73	27	45	27	9	18
Malange	82	0	54	23	46	8	8	8
Moxico	85	5	20	25	20	20	10	10
Uige	83	0	92	44	32	32	12	32

Source: Mapas Sanitarios.

The same list of medicines used in the MINSA/WHO study of availability to medicines at health facilities found that the availability in the formal private sector (pharmacies and drug shops) was comparatively high (73 percent). It was not possible to determine whether the procurement prices paid for medicines by MINSA impacted on the ability to procure more items, and therefore impacting on availability. However, weaknesses in the distribution system (warehousing and transportation) have been known to result in losses due to theft and waste. Medicines procurement through MINSA are supposed to be made available free of charge to patients. The DNME has expressed concerns about the potential for abusive pricing in the private sector but there has not been any study conducted in Angola to evaluate medicines pricing in the private sector. In an effort to identify potential options for increasing access to essential medicines, UNICEF has agreed with MINSA to support a comprehensive country assessment of essential medicines that includes both the private and public sectors. The Terms of Reference for this study are currently being drafted.

QUALITY

Angola's porous borders, unrigorous procurement practices, poor storage conditions, and limited inspection capacity foretell of a high probability of medical product quality problems. The ability to prevent the circulation of counterfeit or substandard products has been documented in Angola and is a matter of concern for both the private and public sectors (Guardiano et al. 2007). The DNME has taken this situation seriously and with the support of WHO and international partners, has started to implement interventions aimed at minimizing quality problems, starting with a product registration system and a drug quality control lab. The DNME recently joined the network of countries reporting potential adverse drug reactions to the Uppsala Monitoring Center (UMC) based Sweden. As a member of this network, the DNME will be requested to submit cases of potential adverse reactions to medicines, potentially related to poor quality medicines, to UMC for evaluation. The DNME also intends to complement this by developing a more active system of local level evaluation.

Although the DNME has identified many key issues and interventions to improve the quality of pharmaceutical products and services, the major risk that the DNME runs at this point is the lack of strategic implementation plan to guide optimal resource allocation within this grand scheme. A strategy is needed to support prioritization of investments so as to be sure to achieve the minimally necessary gains needed before embarking on initiatives that could be considered less urgent or render investments useless if not sequenced properly, including training of specialists to carry out various functions of the new regulatory entities.

EQUITY

By definition, the goal of an Essential Medicines Program is to secure the medical products for the most basic public health needs in a country. However, facilities that are intended to reach the most vulnerable populations are the most likely to not have any medicines. When stock-outs occur, there are three possible scenarios: the budgetary units can use their budgets to fill the gaps, the patients can purchase their medications in the private sector, or they will go without. The now suspended practice of *comparticipação* demonstrated that some population groups were willing and able to pay for their medicines. However, in the absence of any controls the authorities were rightly concerned about the ability to guard against the potential of abusive pricing. There is no prescriptive guidance to the provincial or lower level budgetary units about how to cover for shortages in their supplies and until there is some normalization based on improved demographic, epidemiologic and health services utilization data, concerns about equity should remain high on the agenda.

EFFICIENCY

The most concerning issue with respect to the efficiency of the pharmaceutical supply system is the dependency of the procurement on state of the global economy relative to Angola's two major exports, petroleum and diamonds. While MINSA has tried to be creative in trying to fill gaps in supply that result from failed tenders or from the purchase of insufficient quantities, the costs of otherwise avoidable events are likely to be staggering. These would include the loss of economies of scale and increased transaction costs associated with making more yet relatively small purchases, and, importantly, the cost of not providing treatments that results in prolonged illness, loss of productivity, and death that can be averted. The consequences of the lack of availability should also include concerns regarding family planning and reproductive health products without which lead to otherwise avoidable pregnancies and an added burden to the social and economic development of the country.

The existence of multiple supply channels used by different vertical programs is another source of inefficiencies. Although most of these programs are using MINSA logistics-oriented management system platform, the data is not integrated and data bases are not necessarily compatible so that the data can be analyzed in a manner that could tell the story about the availability of stock in any of the regional or provincial warehouses, in any of the health facilities, including the use of the medicines to the patient level. These inefficiencies stem from the use of multiple warehouses, transportation systems, information systems, and monitoring and supervision. A coherent pharmaceutical management information system would allow for a more efficient and effective management of medical products that would be able to take into consideration issues of safety and quality of the medicines. Seeking more compatible integrated systems, while promoting greater oversight responsibility, could increase overall efficiency. However, until donors can feel more confident in the ability of a MINSA system to deliver products and services, it is unlikely that full integration will occur. As mentioned above, presumably the comprehensive study that will be carried out with UNICEF's support should reveal various opportunities for leveraging the relative strengths of the public and private sectors to achieve improved efficiencies and greater effectiveness of the supply system.

SUSTAINABILITY

Although the pharmaceutical management system in Angola can be characterized as being in a remodeling phase, regardless of whichever restructuring occurs, the greatest threat to the system is the dependency of the general state budget on the global economy relative to its primary exports. As donors step up to help fill the gaps during down times (mostly through vertical programs) Angola has created another dependency that is also vulnerable to externalities over which the country has little control. Changing the financing of medicines is likely to be a dramatic effort that is not likely to be accomplished quickly or easily as the political costs can be high. As Angolan civil society becomes increasingly engaged in issues of social and economic development there may be pressure to demonstrate improved performance, and political support for one or another intervention may be seen as an opportunity to take the credit or the blame for performance issues, particularly during the periods leading up to an election.

The fact that the new drug registration system includes a fee, a portion (40 percent) of which will be used to finance some of the recurrent costs of the system, is a positive development, even if the fee does not cover the entire cost for processing the registration. The drug registration system is also designed to support the development of the local economy by providing incentives for local manufactures to participate in the legitimate market in the form of a reduced registration fee.

Although MINSA has plans to improve the quality of specialized pharmaceutical services, these improvements will not come quickly. It will face human resources constraints for some time until local personnel are trained and posted while is also faces the challenge of a “brain drain” of these new professionals unless the working conditions in country are perceived as sufficiently favorable to retain them.

TABLE 27: SUMMARY OF MEDICAL PRODUCTS MANAGEMENT IN TERMS OF THE HEALTH SYSTEMS PERFORMANCE CRITERIA

	Equity	Access	Efficiency	Quality	Sustainability
Strengths and Opportunities	With decentralization, provinces will be able to manage their own budgets, although there is limited capacity at this time; Apparent capacity for some form of cost-sharing that can shift burden away from those unable to pay.	Access to facilities and private sector, but medicines and vital equipment are not available; better availability in the private sector	Basic package of services to guide integration beyond essential kits. Donor willing to consider service integration including supply system. Private sector distributors could reduce procurement time.	Definition of a quality assurance system exists with political commitment and donor support; allows for systematic building of the system if there was a strategic plan	Decentralization pushes issues of responsiveness and accountability to the lower levels for supply management. Potential for cost sharing
Weak-nesses and Threats	Political risk associated with moving away from free medicines; No guidance to decentralized budgetary units on budgeting for medical products needs.	Supply is irregular; the more remote and impoverished areas do not have access to facilities or medical products.	Multiple small purchases at different levels (loss of economies of scale); lack of donor confidence in MINSA supply chain results in parallel systems for programs, duplication and stretching of scarce resources for monitoring.	Lack of capacity to regulate and enforce the private sector at all levels; lack of a prioritized strategic plan may lead to random investments without achieving meaningful results.	Decentralization does not address the fundamental issue of lack of a stable national/state budget; provincial and local levels not prepared to conduct major purchases.

4.5 HEALTH INFORMATION SYSTEMS

4.5.1 OVERVIEW

Like other countries, Angola's health information consists of vital statistics, population surveys and special studies, routine information generated by the service delivery system, and management information such as a health worker database. Angola has acquired much new and valuable health information since 2005 (see Table 28), including provincial health maps, the Malaria Indicator Survey (MIS) 2007, Emergency Obstetric Care (EMOC) study 2007, Antenatal Care surveillance (ANC) 2009, and the Nutritional Status Survey 2007. MINSA is promoting a national campaign for birth registration. Routine data capture and reporting function better in select provinces. UN agencies, the former EU PASS Project, Center for Disease Control (CDC), and USAID SES Project, among others, have contributed to building capacity to collect and use health data for decision-making at the central, provincial, district, and facility levels.

TABLE 28: WHAT'S NEW SINCE 2005 IN HEALTH INFORMATION SYSTEMS

2005	2010
<ol style="list-style-type: none"> 1. No reliable or complete data on health delivery system (facilities and staff); 2. MICS 2001; 3. Many different forms to serve vertical health programs; 4. Routine facility data not reliable; 5. Surveillance system functioning well with support from WHO and CDC; 6. Data not being used for decisions <ol style="list-style-type: none"> a. Generally flows one-way from the bottom to the top b. Data collectors at the bottom with limited ability or incentive to use the data; 7. No drug inventory management system. 	<ol style="list-style-type: none"> 1. Detailed health maps for 11 provinces; 2. QUIB-2005/6, MIS 2007, EMOC 2007, ANC Surveillance 2004/05/09/09, Nutritional Status 2007, IBEP/MICS 2008 ; 3. On-going effort to harmonize vertical health program forms and reporting systems; 4. Routine data reliable in select provinces; 5. Surveillance system continues to function with external support; 6. Capacity being built for data use: <ol style="list-style-type: none"> a. Health workers trained in data use by SES Project b. DPS trained to use data for planning and budget advocacy c. Incentives to use data; 7. Drug inventory management system beginning to be used.

There are important health data scheduled to be released by July 2010 – the MICS 2008 including a household wealth and expenditure survey (IBEP) with support from UNICEF, and Angola's first National Health Accounts for 2006-2008 with support from WHO and USAID. Since 2001, GEPE/MINSA has been trying to establish a single HIS and database, and harmonize and simplify routine data collection forms. The Health Metrics Network recently assisted GEPE/MINSA to complete a detailed assessment of Angola's HIS.

Angola still experiences significant delays and restrictions on the release of information. For example, the annual health statistics reports for 2007, 2008 and 2009 are not available; and public health expenditure data analysis stopped in 2005. Individual patient records are a rarity at the primary care level, an obstacle to clinical decision-making. A notable gap is the lack of a national census since the 1970s. Data management capacity below the national level is limited. There is no national HIS strategy to address these problems.

4.5.2 HIS REGULATIONS AND POLICIES

Decree no. 32/2000, article 3 identifies the National Statistics Institute (INE) as the state entity responsible for the production and dissemination of official statistical information. Article 21 defines the responsibilities of INE's Department of Demographic and Social Statistics to collect and analyze data provided by line ministries such as MINSA that are members of the National Statistics Council. The official sources of HIS data include public and private health facilities of all levels, the central programs of MINSA such as the National Public Health Directorate and the National HIV/AIDS Institute; the provincial health directorates (DPS), the Ministry of Justice to record births, deaths, and marriage; the Defense Ministry regarding the military health system, private and state companies that provide health benefits to employees, as well as the INE. The draft National Health Policy calls for 2 percent of the health budget to be allocated to health research.

4.5.3 HIS COMPONENTS

POPULATION DATA – VITAL STATISTICS AND CENSUS

Population data are fundamental to health outcome measures and necessary to implement representative household surveys by providing a sample frame. This is one of the weakest areas of Angola's HIS. Due to the absence of a national census since the 1971, accurate population data is not available and there are diverse estimation methods being used. The 11 provincial health maps done by GEPE used the population estimates for 2005 based on vaccination campaigns. Some of the health map estimates were significantly different from previously accepted estimates. Death certificates are not consistently prepared by hospitals. Cause of death is often missing. Death certificates outside the formal health system are very limited. MINSA is promoting a national campaign to register births and district committees, chaired by the district administrator's wife, to audit maternal deaths.

SURVEYS AND SPECIAL STUDIES

Since the end of the war, Angola has benefited from several household surveys and other studies. However, the MICS 2001 (published in 2003) is still the only source for infant and child mortality rates. Everyone is anxiously awaiting the results of the MICS/IBEP 2008. The major surveys and studies completed since 2005 include the following:

1. The Malaria Indicator Survey in 2006-2007 established a baseline for major malaria interventions such as household ownership and use of insecticide-treated nets (ITNs), and the proportion of children under five with fever treated with artemisinin-based combination therapy (ACT) within 24 hours of the onset of illness and the proportion of pregnant women receiving two doses of intermittent preventive treatment (IPTp). (<http://www.measuredhs.com>). New data on malaria interventions is forthcoming in the MICS/IBEP 2008;
2. The ANC Surveillance 2007 provided HIV prevalence data based on biomarker survey of pregnant women. The 2009 ANC study will be released soon;
3. The Nutritional Survey 2007 was a nationally representative sample of children under-five and households. It looked at nutritional status, incidence of disease (fever, diarrhea, and upper respiratory), access to treatment by type of facility, and household health practices;

4. District profiles are comprehensive and detailed descriptions of districts under the direction of the Ministry of Territory Administration with USAID, Chevron, Care, Save the Children, and a Development Workshop, a local NGO. The Profiles are part of the District Development Project (PDM in Portuguese) supporting the government's decentralization process. District profiles cover governance, physical, environmental, institutional, social, and economic factors. The participatory methodology involves district administration and community, and includes photos and GIS coordinates. The team is aware of three completed profiles: Cabinda, Chicala in Huambo, and Cuito Cuanavale in Kuando Kubango province;
5. The Provincial Health Maps are detailed studies of all public health facilities in a province, including building dimensions and condition, personnel, equipment, photos, GIS coordinates, and cost data. All the map data are available in a searchable database at GEPE. Development of the provincial health maps began in 2007 and as of April 2010, 11 provinces had been completed, including Bengela, Bié, Cabinda, Cunene, Huambo, Huila, Luanda, and Malange. A major challenge will be to update the maps regularly. For GIS mapping, Angola lacks a single national data dictionary for labeling all place locations in the country. MINSA plans to complete health maps for all 18 provinces by the end of 2010;
6. The EMOC 2007 provides a picture of maternal health services;
7. Upcoming and proposed surveys and studies:
 - a. National Census
 - b. Demographic Health Survey
 - c. Annual rapid KAP survey among the 18 districts targeted by the new World Bank project
 - d. Completion of the health maps in the remaining seven provinces and broad access to GEPE's searchable database with GIS mapping features
 - e. A national human resource management information system, of which public health professionals would be a part; or a stand alone MIS for health professionals
 - f. AIDS Indicator Study (AIS) for 2010
 - g. The Priority for Local AIDS Control Effort (PLACE) study for Luanda
 - h. Behavior Surveillance Studies (BSS) to inform HIV prevention programs for most at-risk populations such as young women, truckers, uniformed services, miners, and prisoners.

ROUTINE SERVICE UTILIZATION DATA

The routine health information is called SIS (*Sistema de Informação Sanitaria* in Portuguese). SIS data flows through a paper-based system from district hospitals, health centers and posts to the DPS. Where in operation, the RMS participates in the information flow; otherwise this level is bypassed. Data that are processed through the routine health information system includes data from the following areas: volume of consultations, epidemiological surveillance (see below), "hospital" data,¹³ nutrition, diarrhea, child health, lab tests, stomatology (medical study of the mouth and teeth and their diseases), and reproductive health (family planning, contraceptives, prenatal care, maternal mortality). For health units,

¹³ Health centers also report on this information, which includes inpatient data (admittances, transfers, deaths, deaths occurring within 48 hours, and so on).

additional reporting requirements may also occur when individual programs receive funding through external partners and must comply with their reporting requirements. According to SES, most facilities do not have individual patient records. This was identified as a serious obstacle to improving maternal health outcomes, since a complete and accurate patient history was not accessible to the attending clinician during delivery. SES is piloting a patient record for pregnancy. The value of a patient record is also recognized for HIV/AIDS patients and Angola's last National Strategic Plan for HIV/AIDS called for introduction of an information system for patients on ARVs.

The DPS is responsible for managing all health activities for the province. It has three major departments: (1) department of public health and epidemiological control; (2) department of medical assistance and hospital activity, and (3) department of statistics, planning, and infrastructure. All health facilities in the province are required to submit health information (epidemiological and budgetary) to the DPS. The DPS is then tasked to process and analyze all health information from the province, and send it to the central level: MINSA's GEPE and each program under the DNSP. The national programs process their own data.



ROUTINE EPIDEMIOLOGICAL SURVEILLANCE DATA

The National Epidemiological Surveillance System consists of daily data capture at the facility level, aggregated for a monthly notification system to produce a monthly bulletin. Suspected cases of polio, measles, neonatal tetanus, meningitis and malaria are to be actively collected weekly through the "Rapid Alert System" (*Sistema de Alerta Rápida*) and disseminated in weekly and monthly bulletins. Provincial hospitals also report routine health information to the DPS, but they are also supposed to report suspected cases to districts through the alert system. The surveillance

system still lacks adequate lab capacity at the periphery level. There has been visible investment in lab equipment in the health centers, but training of lab technicians and availability of reagents have been obstacles.

PMI has supported two malaria surveillance initiatives. The first involved a partnership with provincial NGOs in four provinces (Malanje, Kwanza Norte, Kwanza Sul, and Huambo) to improve malaria diagnostics and the information system. PMI support for this initiative will end in FY10 because PMI found that, "Since these cases are clinically-diagnosed, not all districts report on a regular basis, and there are delays in releasing reports to the NMCP, these data are of limited use for the detection of epidemics." The second PMI-supported surveillance effort is the Malaria Early Warning System in partnership with WHO. The National Epidemiological Surveillance System collects weekly reports on malaria from the epidemic-prone provinces in the south (Cunene, Kuando K., and Namibe).

Although the National Malaria Control Strategy for 2008–2012 includes early detection and rapid containment of malaria epidemics as one of its objectives, district- and provincial-level epidemic control plans do not exist and existing systems for epidemic detection and response are generally weak and poorly organized." (Malaria Operational Plan 2010).

The National Institute for the Fight Against AIDS (INLS) collects HIV data from the routine facility-based HIS, blood banks, sentinel surveillance and VCT (voluntary counseling and testing) sites, and targeted

studies. For example, KAP studies of youth or most-at-risk populations, and the ANC Surveillance Survey in 2007 based on biomarker survey of pregnant women. Also, in theory, AIDS cases would be reported by health facilities offering treatment (e.g., Hospital Divino Beneficio).

HEALTH MANAGEMENT INFORMATION SYSTEMS

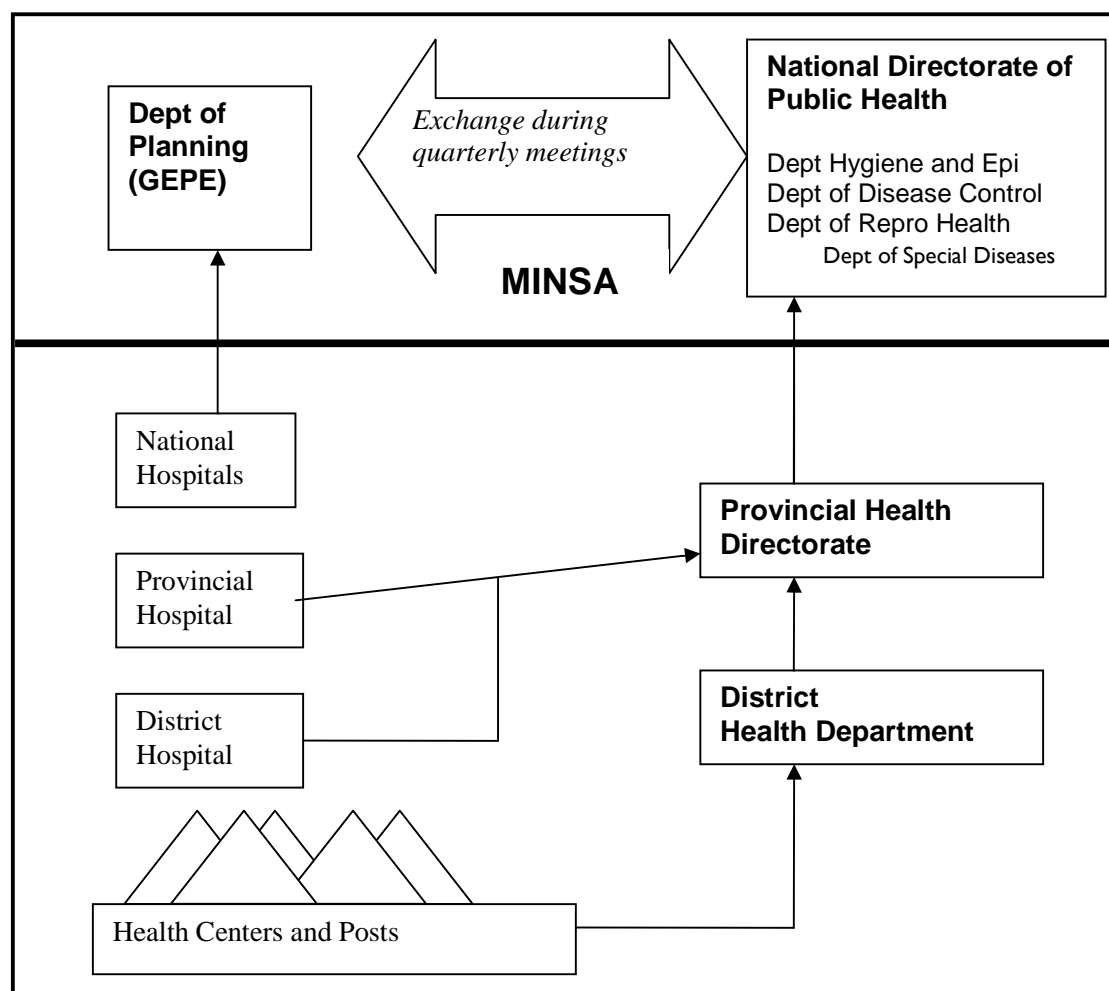
The inventory record keeping system is gradually being rolled out for group and local purchases (see Medical Products section). There is an opportunity to introduce a single inventory management system that supports the needs of multiple programs. MINSA introduced a Spanish HMIS software system in early 2009 but there is no reference to this system in the preliminary HMN assessment report. The team did not find any other functioning management information systems, however a few are hereby proposed:

1. As noted in the human resources section, MINSA proposes to establish a database of public health workers;
2. As noted in the service delivery section, the database of the provincial health maps represents a rich information system of the network of public facilities. This system gathers service data as well as infrastructure and is linked to the district planning system. Hopefully GEPE will go forward with plans to make the database widely available, which will increase the likelihood that the data will be used and updated; and could eventually be linked to the HR database;
3. As noted in the financing section, the PASS project has assisted GEPE to produce analyses of health financing and WHO is currently assisting GEPE to complete the first-ever-national health accounts. Both efforts require analysis of the state budget categories in order to consolidate all health-related spending. Currently, there is no routine production of health financing information, even of public health expenditures.

ISSUES

The flow of routine health information is completely one-way from the service delivery and surveillance locations to the national level (see schematic representation in Figure 11). Also, facility level workers make limited use of the data they collect. One exception is the number of essential drug kits allotted to a facility is based on volume of consultations. Unfortunately since procurement of the kits has been so uneven, this “reward” for timely data collection has not been functional. This situation dampens the front-line workers’ motivation to collect quality data, and threatens the utility and credibility of the whole routine HIS. The draft National Health Policy (PNS) formally recognizes the need for, “...feedback from the central and intermediate levels to the informant level” (MINSA 2009, p. 33). Also, it is not clear to what degree private health facilities contribute their data.

FIGURE 11. GENERAL SCHEMA OF THE PUBLIC ROUTINE HEALTH INFORMATION SYSTEM – SERVICE UTILIZATION AND SURVEILLANCE DATA



4.5.4 A SINGLE HEALTH INFORMATION SYSTEM

The routine HIS is burdened somewhat by the national programs that maintain their own vertical datasets and forms. Different groups developed data collection forms at different times. All the programs, as well as other MINSA institutes, are supposed to meet regularly to share and reconcile data with each other and with GEPE. A 2000 decree charges GEPE with the responsibility for preparing annual plans and budgets in collaboration with other organs, as well as coordinating the periodic assessment of the state of the health of the nation. After each data reconciliation meeting, GEPE compiles the health data that MINSA is to disseminate as a quarterly and an annual publication. This process appears to be non-functional given that the annual statistical publication, the “*Anuário*”, has not been released since 2006!

MINSA’s district health system strategy calls for a unified HIS that harmonizes the requirements across vertical programs to simplify and integrate the process of data collection and aggregation. GEPE is working to implement this vision of the HIS. Obstacles include the reporting requirements associated

with the significant vertical funding for HIS, for either routine data capture or surveys, for particular programs such as HIV/AIDS, malaria, and vaccination/EPI.

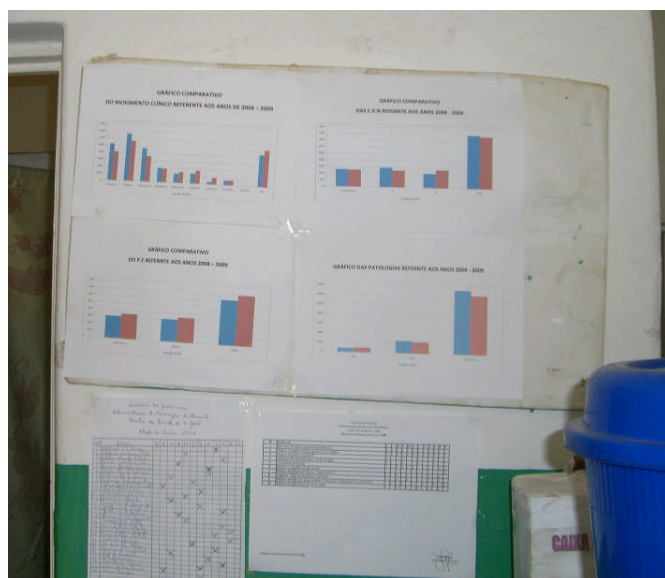
4.5.5 DATA QUALITY

As noted above, the one-way flow of routine health data does not motivate the people collecting the data to be concerned about data quality. While better in some provinces, the routine HIS still suffers from missing and damaged reports, inconsistent classification (e.g., diagnosing fever as malaria without a test) and data management (notification, filing, data use, and interpretation).

The completeness and accuracy of data varies according to the program. For instance, the WHO-supported epidemiological surveillance program provides manpower and vehicles to verify data quality. Throughout the month, the vehicles circulate throughout Luanda province so that provincial and district supervisors can check data reported on submitted forms against registers. In Luanda, the provincial director of the surveillance division actively seeks to obtain complete data from private providers,¹⁴ as well as from other MINSA departments, such as the National Blood Centre. Programs with fewer resources are not able to provide the same level of data quality oversight.

In addition to data quality problems due to human error and lack of resources to do checks, there are some systematic errors noted by the teams that completed the provincial health maps. Few inpatient facilities report admissions, so bed occupancy rates are not calculated. Data on the stock of vaccines at the facility level is inadequate. Frequently, facilities lack maternal health data, such as prenatal or family planning visits (MINSA 2007).

4.5.6 DATA ANALYSIS AND USE



GEPE and the national programs under the DNSP continue to have the capacity for manipulating and using data for programming. However, the disconnect between the government's planning and budgeting process and the process for receiving and spending funds (see Financing section), does not reward people for using health information for planning and budgeting. Vertical programs, such as malaria and HIV/AIDS, appear more likely to use data to monitor results in part due to donor support and accountability. For example, the National Malaria Control Program, with support from PMI and other partners, is implementing a new national policy regarding the use of Rapid Diagnostic Tests and greater lab capacity, which will improve the data on

malaria prevalence, as well as avoid unnecessary treatment.

¹⁴ The private sector is supposed to report into the HIS, though not all private clinics do.

Several DPS and district staff also have capacity to do data analysis in terms of computer equipment and staff training from the EU's PASS project, USAID's SES, and other partner efforts. The team saw many graphs and tables on display at the facilities visited. The DPS are supposed to develop provincial health strategies, but no strategies have been done. The provincial health maps (discussed above) are a major advancement and provide a detailed basis for the elaboration of health strategies and development plans at the provincial level, and is expected to be part of the new World Bank and EU health projects.

With decentralization to the district level in full swing, there is an urgent need to improve data use at the district and facility levels, which in turn will contribute to data quality. HIS training should be integrated with clinical and management training so participants can learn how to use data for clinical and managerial decisions. Routine supervision should make use HIS data and reinforce good HIS practices for data collection, analysis, and use.

4.5.7 SUMMARY OF FINDINGS: HEALTH INFORMATION SYSTEM

This section summarizes performance of the health information system in terms of the health system assessment criteria.

TABLE 29: PERFORMANCE OF THE HEALTH INFORMATION SYSTEM IN TERMS OF THE HEALTH SYSTEM ASSESSMENT CRITERIA

	Equity	Access	Efficiency	Quality	Sustainability
Strengths and Opportunities	New population-based survey data available and forthcoming to monitor equity and access; especially the MICS-IBEP 2008 that has data on access and household health expenditures by income level. Opportunity for data to inform better targeting of health resources. Opportunity for expenditure data to monitor equity.		Broad consensus on the need for more harmonized HIS that is integrated and streamlined at the facility level. Reinforced by the district health strategy emphasis on primary health care.	HMN assessment done in 2009. Broad agreement on the need to improve data quality and use of data to improve the quality of clinical care. Pilot of patient record for maternal health.	Several unfinished efforts to improve HIS and address fragmentation. Will the combination of the district health strategy and support from Health Metrics Network achieve real improvements?
Weaknesses and Threats	Limited access to data and information. Will politically sensitive survey results constrain dissemination and use? Will the health maps be updated to show gaps in access? No routine production of health financing information, even of public health expenditures that help could monitor equity.		Vertical funding and reporting requirements from donors. Limited infrastructure for computer, mobile phone, or internet-based HIS.	Lack of recent census is an obstacle to accurate surveys. Routine data often missing or inaccurate. One-way flow of routine data does not motivate health workers to ensure data quality.	One-way flow of routine data does not motivate health workers to sustain data quality, and threatens effectiveness of training.

4.6 SERVICE DELIVERY

Service delivery is where all the health system components come together: issues and constraints in governance, financing, human resources, essential medicines and information systems will all affect the performance of service delivery, directly or indirectly. This section will focus on the aspects that are closest to the service delivery level, referencing the relevant issues discussed in the other sections.

TABLE 30: WHAT'S NEW SINCE 2005 IN SERVICE DELIVERY

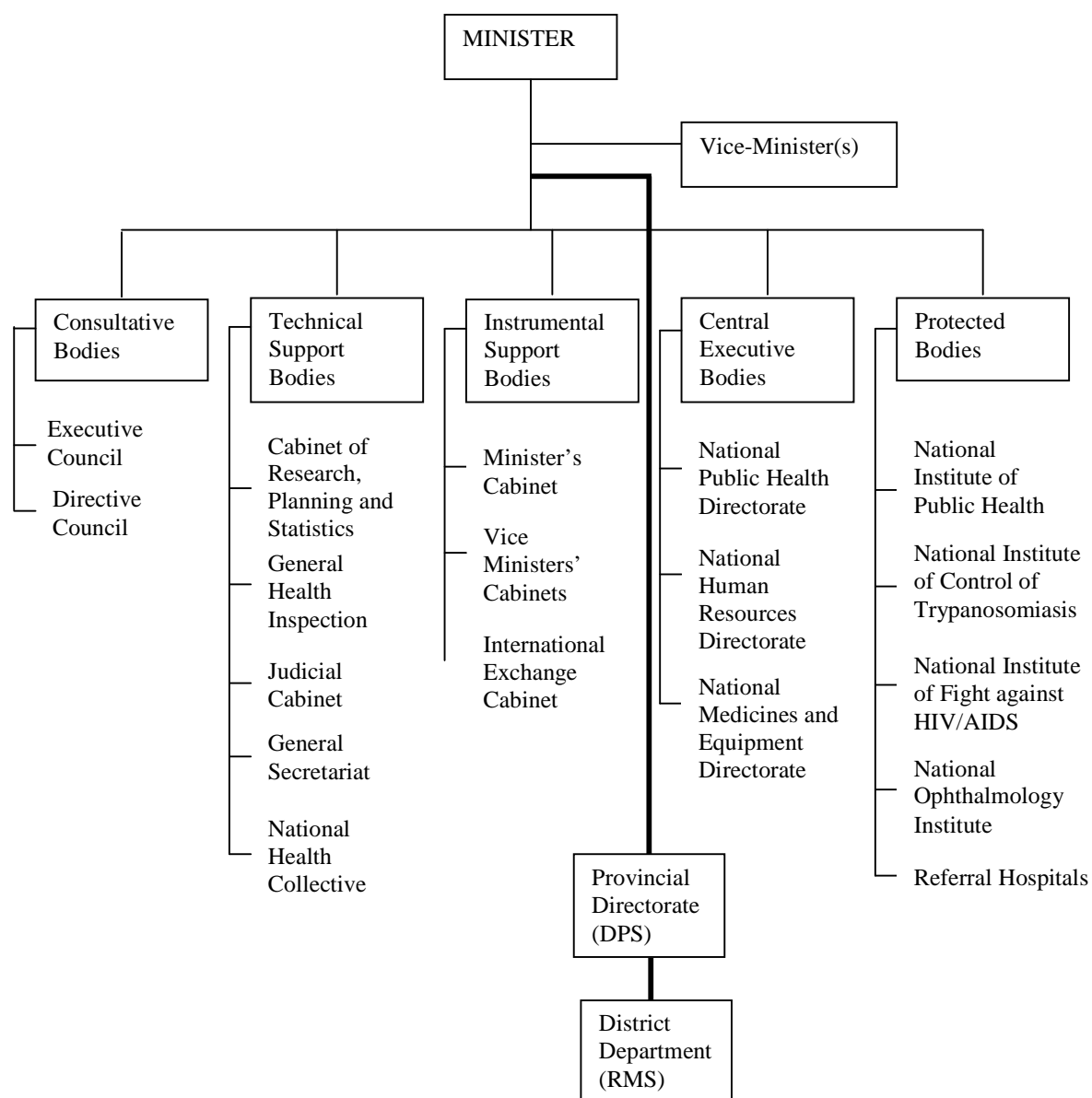
2005	2010
<ul style="list-style-type: none">• Insufficient number of health facilities;• Lack of information about the relevance and adherence to REGUSAP classification of health facilities;• Limited number of clinical norms;• No quality assurance mechanisms;• Little information on and engagement with private health facilities;• Lack of basic equipment in health facilities;• Vertical programming and services delivery.	<ul style="list-style-type: none">• Significant increase in number of health facilities;• Mapas Sanitários providing valuable information on applicability of REGUSAP to health facilities;• More clinical norms developed by national programs, but dissemination and use still limited;• Still no national mechanism for quality assurance, but some experiences in select provinces;• More information available on role of private providers and facilities, some experiences with partnerships• Lack of basic equipment still chronic;• Consensus and strategy to integrate services with a focus on primary care.

4.6.1 ORGANIZATION OF MINSA AND SERVICE DELIVERY

A 2000 decree organized MINSA into five bodies: consultative, technical support, instrumental support, central executive, and protected (see Figure 12). Each function is subdivided into two to five areas (e.g., directorates, cabinets, institutes, or councils), each with its own hierarchy. As in 2005, it is not clear whether MINSA operations actually follow this structure and whether it is the most appropriate for MINSA needs and functions.

In addition to the disease/health-area specific Institutes under the “Protected Bodies” of MINSA, there are several national programs under the National Directorate of Public Health such as the Reproductive Health Program and the Nutrition Program.

FIGURE 12. MINSA ORGANIZATIONAL CHART 2009



Source: MINSA website.

Administratively, MINSA has three levels:

- **Central:** this includes the cabinets of the Minister, Vice-Ministers, and all of the five functions and their subdivisions in Figure 12;
- **Provincial:** this includes the Provincial Health Directorates (*Direção Provincial de Saúde*, DPS), which depend administratively on the Provincial Governments and technically on the central level MINSA;
- **District:** this includes the RMS, which depend administratively on the District Administration and technically on the DPS and the central level MINSA. The RMS constitutes the health authority at the district level.

The RMS is a new unit created approximately two years ago that evolved from the former district health sections, directorates, and delegations. As its predecessors, the RMS is not a budgetary unit (see Health Financing section for a discussion on budget authority and the Summary of Findings and Opportunities section for a discussion of RMS and decentralization). Upon its inception, there was no clear guidance on the functions to be executed by the RMS. The district health strategy proposed a series of functions for the RMS, described in Box 7.

In the Huambo province, the DPS worked with several donors (USAID, EU, and UNICEF) to select three districts to serve as pilots in operationalizing the newly proposed RMS functions: Huambo, Caála and Bailundo. The partners carried out a workshop with these RMS where they worked on a plan to implement the district health strategy. They also developed detailed district profiles to provide information for the plan (such as number and condition of health facilities). The RMS submitted their plans to their respective district administrations; however, none of the plans have been executed to date because the RMS has not received any funds. As noted in the previous Health Financing section, a challenge of moving from plans to action is lack of resources.

Box 7. Proposed Functions of the RMS under the District Health Strategy

- 1) Disseminate and implement MINSA norms and policies
- 2) Manage human and financial resources, including continuing education
- 3) Propose to the DPS the hierarchy, reclassification, remodeling and creation of Health Units according to the population needs and the referral and counter-referral system
- 4) Elaborate a yearly operational plan with a budget, including the different public health programs and community participation
- 5) Promote “co-responsibility” in improving quality of life of populations, in coordination with NGOs, the private sector, civil society and other government agencies
- 6) Support the Birth Registry of every child born in its jurisdiction in collaboration with the Ministry of Justice

Source: Revitalização do Sistema Nacional de Saúde a Nível Municipal. Third Draft. MINSA, 2009.

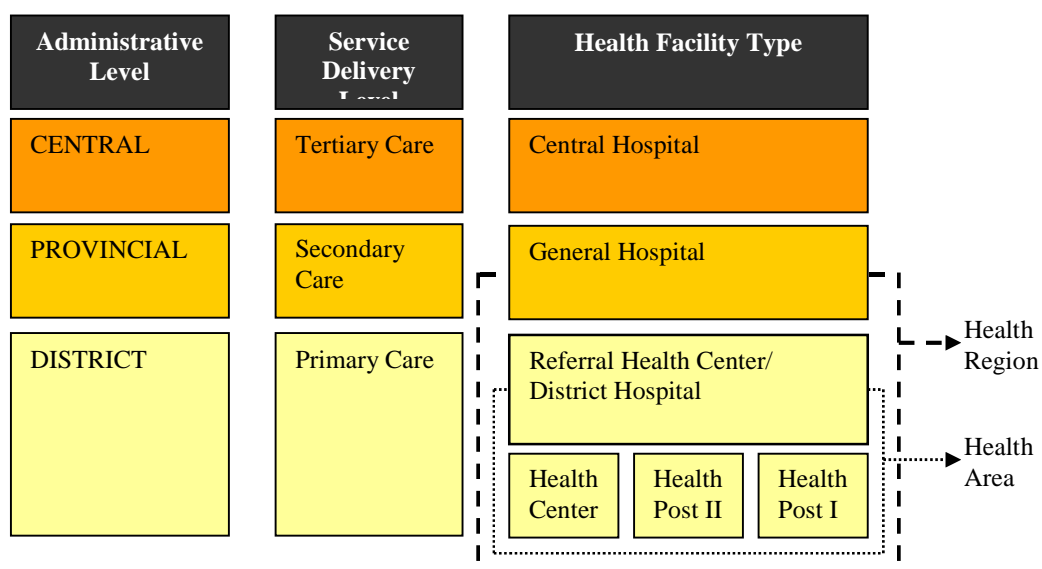
Health service delivery is also divided into three levels in Angola: primary, secondary and tertiary, each with corresponding health facilities.

The different levels of health service delivery serve as the basis for the delineation of “Health Areas” (*Áreas de Saúde*) and “Health Regions” (*Regiões de Saúde*) (MINSA 2009):

- **Health Area:** encircles the area around a referral health center or district hospital, tending to correspond to a district. However, one district may have more than one health area. The health area is the territorial unit for the management and delivery of primary health care services;
- **Health Region:** usually includes multiple districts and corresponds to a province, encircling the areas around a general hospital. The health region is the territorial unit for the management and delivery and integration of primary and specialized care services.

Figure 13 summarizes the administrative and service delivery levels and the types of health facilities of the Angolan health system.

FIGURE 13. SUMMARY OF ADMINISTRATIVE AND SERVICE DELIVERY LEVELS OF THE ANGOLAN HEALTH SYSTEM



4.6.2 HEALTH FACILITIES

Table 30 displays the number of functioning public health facilities in Angola from 2003 to 2009 by type (the team could not obtain the data by province). The total number of functioning facilities has almost tripled between 2003 and 2009, driven mostly by an increase in health posts, followed by health centers, then district hospitals. Some of this increase is a direct result of a health facility construction boom that has happened since 2000, although some of it may be the result of previously non-functioning facilities (reported as 830 facilities in 2002) becoming functional (Angola HSA 2005). The significant increase in health centers and health posts may be an encouraging sign of greater emphasis on primary care.

TABLE 30: NUMBER OF HEALTH FACILITIES IN ANGOLA BY TYPE FROM 2003-2009

Facility Type	2003	2004	2005	2006	2007	2008	2009
Central Hospital	9	9	9	9	9	9	9
General Hospital	33	33	33	33	33	45	45
District Hospital	52	116	116	132	132	146	155
Health Center	162	272	272	313	316	359	359
Health Posts (I&II)	696	1,026	1,026	1,468	1,472	1,841	1,841
TOTAL	952	1,456	1,456	1,955	1,962	2,400	2,409
<i>Source: GEPE/ 2009</i>							

The REGUSAP specifies the infrastructure and staffing requirements for each type of health facility, what population they should cover, the services they should offer and the equipment they should have. Table 31 displays the general services that should be provided and the population coverage for each primary and secondary health care facility type according to the REGUSAP. Because the Referral Health Centers/District Hospitals and General Hospitals are referral facilities, their coverage may overlap with that of lower-level facilities; the most basic level of health facilities, Health Centers, Health Posts II and Health Posts I do not overlap in their coverage. In general, the number of existing health facilities still falls short of the REGUSAP requirements, in spite of the recent constructions (Mapas Sanitário Huambo and Luanda 2007).

TABLE 31: SERVICES PROVIDED AND POPULATION COVERAGE FOR EACH TYPE OF HEALTH FACILITY ACCORDING TO REGUSAP

Health Facility	Services Provided	Population Coverage
Health Post I	Primary care (consultations, vaccination, child growth monitoring, pre-natal care, family planning and essential medicines).	5,000
Health Post II	Primary care + laboratory	20,000 to 40,000
Health Center	Primary care + laboratory + labor and delivery Open 24 hr	75,000
Referral Health Centers/ District Hospitals	First referral level Primary care + laboratory + labor and delivery + in-patient care + radiology + nutritional recovery + oral medicine	150,000 rural 500,000 urban
General Hospital	Second referral level Primary care + laboratory + labor and delivery + in-patient care + radiology + nutritional recovery + oral medicine + surgery + blood transfusion + specialized in-patient care in internal medicine, pediatrics and gynecology and obstetrics Some general hospitals offer more services	750,000
<i>Source: Mapas Sanitários</i>		

The Mapas Sanitários revealed many discrepancies between the REGUSAP specifications and the classification of existing health facilities. For example, health facilities that were officially classified Health Post II, were in fact functioning as health centers and vice-versa. As a result, at least the Luanda province performed a reclassification of its health facilities, reconciling the findings from the Mapas Sanitários with the REGUSAP.

The discrepancies also revealed a need to revise the REGUSAP for health facilities, since many facilities do not fall under any of the categories described in the regulation. Based on the analysis of the data from the Mapas Sanitários, the district health plan proposes several changes to REGUSAP.

There has been significant improvement in infrastructure in the past five years with the construction of new health facilities and new roads. Much of the health facility construction was done based on the Mapas Sanitários, so that facilities were built where they were needed. This may explain the improvement in access shown in the MICS survey: from 30 percent in 2001 to 42 percent in 2008. However, lack of basic equipment such as scales, cold boxes for vaccines, and essential medicines is still a chronic problem that poses a barrier to the effective delivery of services.

4.6.3 SERVICES PROVIDED

The district health strategy for Angola has at its core the integration of health services at the district level where primary care services are delivered, geared towards improving maternal and child health through an essential health services package. While the plan prescribes how the integration can occur at the facility level, it is not yet clear how it will be reconciled with the national programs, or with vertical donor assistance streams. Donor coordination has a pivotal role to play in operationalizing goal of integration of vertical programs at district level.

The vertical programs at the central level of MINSA include: Reproductive Health, Child Health, Expanded Program on Immunization, Nutrition, Malaria Control, HIV/AIDS, Tuberculosis and Leprosy, Shistosomiasis, Onchocerciasis and other Parasites, Tripanosomiasis, National Blood Service, Oral Health, Mental Health, and Physical Medicine and Rehabilitation. These programs vary in the degree of their penetration down to the provincial and district levels and their functionality. In general, the programs that receive the most donor support (such HIV/AIDS and Malaria) are the ones with the most capacity and functionality. This can leave serious gaps in programs that should be addressing the health priorities of Angola, namely maternal and infant mortality. For example, the Reproductive Health program has been severely understaffed and lacks the basic resources to run effectively since it lost donor support a few years ago, which seriously undermines Angola's ability to improve its maternal and child health indicators.

Table 32 displays an example from the Huambo province of the services provided by primary care facilities, compared with the required services according to REGUSAP. The cells shaded in green indicate that the service is required in that facility type, and the percentage indicates the proportion of facilities surveyed that provide the service.

This comparison shows mixed results. While many of the essential required services are not being offered in some facilities (most notably, only 10 percent of Health Posts II and 43 percent of health centers are offering family planning services, and only five percent of Health Posts II and 14 percent of health centers are offering oral rehydration), some facilities are providing services beyond those required. For example, 100 percent of referral health centers/district hospitals and 70 percent of health centers are offering short-term in-patient care. A similar pattern was observed in all the provinces that have conducted Mapas Sanitários. The low provision of required services is likely explained by the lack of essential equipment and medicines discussed earlier (see Essential Medicines section), as well as the lack of qualified staff (see Human Resources section). The “overprovision” of certain services (that is, services being offered in facilities that are not required to offer them) may indicate that some facility types could be offering more services than prescribed by REGUSAP.

TABLE 32: SERVICES REQUIRED AND PROVIDED AT THREE FACILITY TYPES IN THE HUAMBO PROVINCE

Service	RHC/ MH (n=14)	Health Center (n=19)	Health Post II (n=25)
Prenatal Care	100%	93%	61%
Family Planning	83%	43%	10%
Infant Monitoring	67%	73%	17%
Immunization	83%	84%	27%
Oral Rehydration	67%	14%	5%
Nutritional Recovery	67%	11%	4%
Consultation	100%	98%	96%
Pre- and Post-partum Assistance	100%	73%	22%
Orthodontics	33%	2%	0%
Curative Care	100%	95%	100%
Emergency	100%	70%	13%
Short-term in-Patient Care	100%	70%	17%
Short-term Maternal in-Patient Care	100%	48%	1%
Long-term in-Patient Care	100%	57%	4%
X-Ray	0%	0%	0%
Laboratory	100%	43%	0%
Blood Bank	50%	0%	0%
Sterilization	100%	20%	0%
Pharmacy	100%	100%	98%
Transportation	83%	18%	0%
Laundry (Facility Maintenance)	83%	11%	0%
Kitchen Services (Facility Maintenance)	100%	14%	1%
Morgue	50%	0%	0%
<i>Note:</i> Shaded cells indicate that the service is required at the facility type. <i>Source:</i> Sanitário Huambo 2007.			

In addition to facility-based care, the REGUSAP also includes “mobile teams”, which are facility-based staff that visit the community regularly to provide preventive care (e.g., vaccination, de-worming, insecticide-treated net distribution, micronutrient supplementation, ante-natal care, HIV testing, and so on). As discussed in the Human Resources section, the reintroduction of CHW also presents an opportunity to support the work of mobile teams and extend health services and promotion beyond health facilities and into communities.

4.6.4 COVERAGE

Table 4 in the Health Status Section (2.2.1) displays health service indicators for Angola over the years. Some indicators show positive trends: vaccination coverage for 3 doses of DTP went from 24 percent (1996) to 34 percent (2001) to 87 percent (2008), and contraceptive prevalence went from six percent (2001) to 18 percent (2008). However, many indicators still show limited progress, notably in maternal health: the percent of pregnant women attending at least one pre-natal consultation went from 64 percent (1996) to 66 percent (2001) to 69 percent (2008) and assisted deliveries went from 45 percent (2001) to 47 percent (2008). There are several possible reasons for low coverage of services, including: physical access to health facilities and staff, availability of equipment and medications, and lack of qualified health service providers (see Essential Medicines and HR sections).

Another issue affecting health services coverage is demand for services. There is little population-based data available in Angola to determine the extent to which people seek health services. Anecdotal evidence from some of the District Profiles and key informant interviews indicates that there may be a preference, especially in rural areas, for the use of traditional medicines and healers (Andulo Municipal Profile 2007). A nutritional survey carried out by UNICEF in 2007 shed more light into the health service utilization practices for child illness in Angola (Table 33 below). According to the survey, 80 percent of children who were ill received treatment, only in 2.7 percent of cases the treatment was sought from traditional healers (MINSA, UNICEF, and WHO 2007). The remainder of services (97.3 percent) was provided at various health facilities. These findings are encouraging, and more information is needed on whether the same pattern is true for adult illnesses and other health services. For example, the percentage of deliveries attended by trained health personnel is still alarmingly low (Table 4 in Section 2.2.1); whether this is mostly due to lack of access or lack of demand needs to be examined.

4.6.5 PRODUCTIVITY AND QUALITY

According to the Mapas Sanitários, the level of productivity of the health workforce in Angola is quite low (MINSA 2009). The average productivity for all técnicos reported for Benguela, Bié, Huambo, Huíla and Luanda ranged from less than one hour to two hours of actual health service provision per técnico per day (Mapa Sanitários for Benguela, Bié, Huambo, Huíla, and Luanda 2007).

Although in general there is a shortage of qualified health professionals in Angola, this low productivity points to an excess in basic-level técnicos in the system, especially in relation to the volume of services provided. The poor distribution of health workers may explain this apparent excess of personnel (see HR Section 4.3.2). While some facilities have extremely high numbers of staff, others are severely understaffed.

In overstaffed facilities, staff may choose to work long shifts even when they are not needed, so they can accumulate and take extended leave later (Mapa Sanitário for Luanda 2007). Another cause of the low productivity is the vertical programming. A facility may have 10 técnicos, but each is trained in a discrete service and is only able to provide that service. To improve integration, the district health strategy calls for training health service providers on the full essential health services package – so that for example, the same person who provides prenatal consultations can also provide voluntary HIV counseling and testing, and family planning counseling. The Mapas Sanitários do note that it may prove a challenge to demand more from the health workforce and motivate them to work more efficiently (see discussion on incentives in HR Section 4.3.6).

Regarding clinical norms or guidelines, some of the national programs (HIV/AIDS, Malaria, and Infectious Diseases) at the central level have developed “treatment protocols” for specific diseases or health areas; at the hospital level, some clinical protocols have been developed. Knowledge and use of these protocols are reportedly low, even among health provider training institutions. The USAID-funded projects have been supporting the development of some of the clinical protocols based on the treatment protocols.

There is no functioning national system for ensuring quality of services in Angola (see HR Section 4.3.8 for a discussion on training and supervision). However, there are some experiences at the provincial and district levels that show promise. In the Luanda province, the DPS has taken the initiative to evaluate and accredit health facilities using an evaluation instrument, encouraging a culture of continuous quality improvement. This initiative is still in its early stages, and the incentives for accreditation are still being worked out. The DPS is also considering expanding the accreditation concept to whole districts, to

encourage different facilities to work together. USAID-funded projects are supporting the implementation of quality improvement methodologies at the DPS level in certain provinces.

4.6.6 REFERRAL SYSTEMS

There are currently no detailed referral systems for health services in Angola. The district health strategy proposes a referral and counter-referral system (MINSA 2009). Each health facility that serves as a first referral level (referral health centers or district hospitals) should have assigned lower-level facilities (health centers and health posts I and II) that refer patients to them. In the counter-referral, the higher-level facilities refer the patient back to their point-of-entry into the system (the lower-level facility) with diagnosis and treatment records for follow up.

The referral and counter-referral system proposed in the district health strategy has three essential functions:

- Clinical: ensuring that patients receive the level of care appropriate for their conditions;
- Continuing education: supporting the continuing education efforts of the DPS;
- Supervision and quality control.

According to key informants, the implementation of this referral system is still very limited.

4.6.7 ROLE OF THE PRIVATE SECTOR

There is limited data on the role of the private sector in health service delivery in Angola. However, a few studies that have been conducted since 2005 are beginning to paint a clearer picture of the private sector's contribution to health service provision.

REGULATORY ENVIRONMENT

Private provision of health services is legal (Decree 34/92), and private providers must be licensed (Sections 3442 of the decree). Private pharmacies are also legal (Decree 36/92, Sections 168). The law regulates the qualifications of all providers (doctors, nurses, pharmacists, and allied health personnel), but MINSA's capacity to regulate private providers is very limited.

The laws for non-profit health organizations (Decree 92, Article 3334) subject such organizations to orientation and inspection by MINSA, and allow public support, both financial and technical. The latter provides a legal basis for public-private partnerships in service delivery. In 2005 the regulation of international NGOs was described as a "long saga", and according to key informants, this has not changed. During the war, the government had some negative experiences with international NGOs that were working in the country without government knowledge or coordination. Consequently, there has been a trend to exercise more control over NGO activities. Compliance and enforcement are uneven. An NGO law (Decree 84/02) allows the government to take retributive action, but no one was aware of any case where the government did take such action against any international NGO.

PRIVATE PHARMACIES

There is no data available on the number of private pharmacies and “medicine posts” (*Postos de Venda de Medicamentos*) in Angola. The only existing professional pharmacist association is in the Huambo province. Private pharmacies and medicine posts appear to have a high penetration, even in rural areas, and are usually better stocked than health facilities in the public sector. Problems with leakage of public sector medicines are widespread (see Pharma section). In the Huambo province, a PMI project is implementing a pilot initiative to work with pharmacies and “medicine posts” to combat the leakage of COARTEM into the private sectors (see Pharma section). If this pilot is successful, it may prove a good opportunity for adding a family planning component.

A KAP survey conducted by a USAID-funded project in 2009 in four districts in Luanda reported that 42 percent of men and 29 percent of women obtain their contraceptives in pharmacies (ESD Project 2009). In a random visit to a medicine post in the Huambo province, the team found oral contraceptives and injectables being sold (the injectable illegally), a possible indication of demand for such products in these outlets. Both Luanda and Huambo are more urban provinces, and it is not known whether private pharmacies are a significant source of medicines or whether health services in rural areas are. The UNICEF national nutrition survey reported that 4.2 percent of treatment sought for child illness occurred in pharmacies (Table 33).

The data from the KAP survey in Luanda and PMI’s experience with pharmacies in Huambo are indications that pharmacies could potentially play a significant role in the provision of health products and even services (such as counseling) in urban areas in Angola. There are many models for working with private pharmacies to improve access to quality and affordable essential drugs along with quality counseling that Angola could draw from to design the most appropriate program for its context (see discussion of Access in Medical Products section).

PRIVATE HEALTH PROVIDERS AND FACILITIES

In addition to private pharmacies, the district profiles identified practicing private nurses and TBAs in some districts, especially in communities underserved by public health facilities. Most of them are practicing without any training or licensing. For example, in one commune in the Andalo district there are a total of 413 practicing TBAs, 350 of which (85 percent) have had no training (Andulo District Profile 2007). Although the Ministry of Family officially supports TBAs, it is not clear whether there are any systematic efforts or plans to train existing TBAs up to a minimum skill level or to officially incorporate them into the health system. In the Huambo province at least two NGOs (Mentor and Save the Children) have carried out TBA trainings. As discussed in the Human Resources section (4.3.5), the CHW cadre recently reintroduced by MINSA has the potential to be developed as a private model to extend health services in rural areas in a sustainable way.

There is still limited data on the proportion of health services provided by private facilities in Angola. The only new data source since 2005 is the UNICEF nutrition survey, which includes the types of facilities where treatment of child illness occurred (Table 33). Overall, 78.3 percent of treatment services for childhood illnesses occurred in the public sector, and 19 percent in private sector facilities. The use of the private sector is highest in Luanda (26.7 percent), the most urban province, which contains almost one third of Angola’s population. In other urban areas the use of private health facilities was 22 percent, and in rural areas 12.2 percent. This data is consistent with many key informants’ perception that the presence of private health facilities is more significant in urban areas. Because these areas are the most densely populated in Angola, this means that potentially a considerable amount of people are receiving health services from private sector sources. As mentioned earlier, MINSA’s ability

to regulate the private health sector is very limited. In addition to regulation, another way to monitor and ensure the quality of services provided in the private sector is by working in partnership with these facilities.

TABLE 33. SOURCE OF HEALTH SERVICES FOR TREATMENT OF CHILDHOOD ILLNESS

Area	Source of Health Services for Treatment of Child Illness											
	Public Sector						Private Sector					Traditional Healer
	Hospital	Maternity	Health Post	Child Health Center	Health Center	Total Public	Private Clinic	Faith Based Facilities	Employer facilities	Pharmacy	Total Private	
Luanda	24.5	5.4	33	0.6	9.1	72.6	9.4	12.9	1.3	3.1	26.7	0.6
Other urban	37.5	0.7	25.3	4.3	9.5	77.3	14.7	2.4	1.2	3.7	22.0	0.9
Rural	37.8	0.8	34.4	0.5	8.7	82.2	5.2	1.4	0.2	5.4	12.2	5.7
Total	35.0	1.7	30.4	2.1	9.1	78.3	9.9	4.1	0.8	4.2	19.0	2.7

Source: Relatório do Inquérito Sobre a Nutrição em Angola 2007. MINSA, UNICEF, and WHO.

In the Luanda province, the DPS is experimenting with a contracting scheme with private clinics to provide services in areas that are not served by public health facilities. The DPS has contracted with 12 private clinics, most of which are for-profit, who provide a pre-defined package of services to a target population (pregnant women, children, the elderly, and people with disabilities) for a fixed amount of US\$ 10 per patient. The DPS reimburses the clinics at the end of the month. The DPS conducts an evaluation of the quality of services provided by the clinic and if results are not satisfactory, the clinic is given the opportunity to improve. This is a new initiative and many of its details are still being worked out, for example, whether the US\$ 10 reimbursement is appropriate, how to work quality requirements into the contract, and whether accreditation should be a requirement for contracting a clinic (see Service Delivery section 4.6.5). This is another interesting model that should be carefully monitored for potential scale-up into other urban areas.

According to key informants, the presence of health service provision NGOs in Angola has not changed significantly since 2005, and compared with other Sub-Saharan African countries, is not as prevalent. The data in Table 33 shows that the use of faith-based facilities is highest in Luanda (12.9 percent).

PRIVATE COMPANIES

The presence of private companies, especially oil companies, continues to be strong in Angola. In terms of health services, while in 2005 most companies had their own clinics and health systems to provide services to their employees and their families, the trend now is to purchase private health insurance, the first of which has recently opened (see Health Financing section).

Private companies also continue to forge partnerships with the Angolan government and with donors (such as USAID) to co-finance health projects, providing a significant amount of resources, especially towards initiatives in malaria and HIV/AIDS.

4.6.8 SUMMARY OF FINDINGS IN SERVICE DELIVERY

This section summarizes performance of the service delivery system in terms of the health system assessment criteria.

TABLE 34: PERFORMANCE OF THE SERVICE DELIVERY SYSTEM IN TERMS OF HEALTH SYSTEM ASSESSMENT CRITERIA

	Equity	Access	Efficiency	Quality	Sustainability
Strengths and Opportunities	Renewed commitment to primary care and integrated services in district health strategy.	Improvement in infrastructure (new health facilities and roads).	Information from Mapas Sanitários allows for informed planning and decision-making.	Clinical guidelines developed. Promising pilot experiences for quality improvement.	Improvement in infrastructure (new health facilities and roads).
		Partnerships with private pharmacies and clinics can help improve access to medicines and services in an efficient way.			
Weaknesses and Threats	Lack of clarity on how integration should work at provincial and central levels.			Clinical guidelines not disseminated or used. Lack of institutionalized quality assurance mechanisms.	
		Lack of basic equipment to provide essential health services.			

5. SUMMARY OF FINDINGS AND OPPORTUNITIES

Based on the findings presented for the individual building blocks, this section presents seven priority issues and specific opportunities and ideas for addressing them. The issues and ideas were raised with local stakeholders in interviews, at the workshop, and through stakeholder review of this report. The suggestions cut across building blocks, for instance solving drug stock-outs will involve financing, information systems, and governance. While most of the problems are priorities for the success of Angola's district health strategy, the ideas and suggestions have merit regardless of the status of the strategy.

5.1 FINANCING OF NON-SALARY RECURRENT COSTS

The public payroll system functions reliably, but financing of other recurrent health expenses is inconsistent and often inadequate due to issues at the central and sub-national levels. Firstly, budget ceilings set by MINFIN are not clearly linked to health sector plans. Also, while each budgetary unit (MINSA, provincial governments, provincial hospitals, and now districts) dutifully submits a final budget within the ceiling set by MINFIN during the June-August budgeting cycle, actual cash released during the year requires further justification, is irregular, and is typically less than the approved budget. For example, as of April this year, several budgetary units in health sector had not yet received any of their 2010 funds. These patterns contribute to the low health budget execution levels, which are in turn used to justify lower budget allocations.

Decentralization to the district level could improve or worsen this situation. Improved resource allocation could come from:

- The visibility of the district health strategy, for example, in April Minister Van Dunen held a public forum covered in the national press with district administrators in Kwanza North to explain their critical role to ensure financial support for the district health strategy;
- UO's higher budget execution rates because they can spend funds as budgeted without additional approvals, though they may still face delays in receiving funds (see Health Financing section);
- Building local capacity to plan. The PDM and UNICEF build district capacity to plan rationally based on community input and achieved a higher percentage of resources allocated to the social sector compared to other districts.

On the other hand, decentralization could worsen the lack of funds for recurrent health costs:

- MINFIN apparently plans to continue to allocate equal amounts to provinces and districts regardless of their size;
- RMS teams are in a weak position to influence the district administrator due to limited technical capacity, and the fact that they report to him or her. In 2005, there was little incentive for the provincial government to address primary health care. In addition, GEPE and DPS have limited

capacity to use health data to influence either the level of resources or their allocation when negotiating with the MINFIN or the provincial governor. These dynamics and weaknesses are now shifting and from 18 provinces and expanding into 164 districts;

- The DPS that were the focus of intense capacity building through PASS and other projects, may now need to spread their advocacy and technical support efforts beyond the governor to the districts;
- Some districts lack a bank, which is clearly an obstacle to the local administration's ability to manage its funds;
- Even if districts plan and budget well, there is a need to closely monitor actual funding flows since existing budgetary units complain of delays in receiving funds.

Several suggestions were identified for the central and sub-national levels.

At the central level, more effective advocacy is needed with MINFIN and MINPLAN for full funding of approved health budgets. Many project interventions have focused on better health planning, but advocacy may need to be elevated to a higher level to resonate with non-health experts within MINFIN and MINPLAN. For example, MINSA should assert:

- The macro-economic implications of Angola's demographic trends (see Box 2 "Making Health a National Priority" in the Country Overview section) and the need for a strong health system to meet the demand for family planning and healthy children and mothers;
- The importance of a well performing health system to foreign investors.

Both MINFIN and MINSA perceive that the problem of low health budget execution resides with the other. However, the team is not aware of any systematic effort to diagnose the problem, and recommends that MINFIN and GEPE collaborate to identify concrete remedies and actions to increase budget execution (absorption capacity). The joint ministerial team should also look at successful practices in other countries, for example advance funding of primary care providers in Kyrgyzstan. This is a high priority given previous and expected investments by MINSA and donors to improve planning and budgeting at the central, provincial, and district levels. Return on these investments and staff motivation to devote time and energy into annual plans and budgets are at risk if there is no impact on actual funding.

Another suggestion for the central level is for improved donor coordination and ways for partners to "speak with one voice" regarding the importance of full funding for approved budgets, and for recurrent health costs.

At the provincial and district levels, several suggestions emerged to assure full funding of the approved provincial and district health budgets:

- Central level guidance from MINSA to district administrators on rules and criteria for resource allocation at local level;
- A budget for each district based on objective criteria, possibly a formula. This approach is found in Eastern Europe and Brazil and is now feasible in Angola based on the data from the health maps and the upcoming census;

- A larger MINSA budget and mechanism to co-finance local allocations based on national priorities or clear local priorities consistent with national policies. This may be an approach to implement one or more of the suggestions for how to integrate vertical national programs at the district level, for example co-financing of integrated supervision;
- Technical support to the RMS to execute their financial management responsibilities from the DPS and partners. The World Bank project plans to provide this in their new project, and there is an opportunity to leverage prior investments to build capacity among the DPS. DPS Luanda, Pathfinder, and other partners began tighter coordination of activities at the provincial and district levels;
- A financial reward for districts to recognize progress against clear, measurable objectives based on the district health strategy. This could be administered by the DPS in each province. The rewards could be paid out of the block grants received by each provincial governor. District performance could be measured by the routine information system and then independently verified to discourage manipulation of the routine information. The World Bank is planning annual surveys in the 18 target districts it will support, and these surveys could provide that independent verification. An example of an inter-governmental pay-for-performance scheme is Argentina (World Bank *Plan Nacer* Argentina 2009);
- As proposed by MINSA, advocacy by the district administrator's wife who is also honorary chair of the maternal death audit committee in each district.

5.2 ESSENTIAL MEDICAL PRODUCTS

The chronic shortage of essential medicines and supplies puts the district health strategy at immediate risk of failure. The absence of basic medical products will compromise the impact of all the other elements. Trained staff will not be able to apply quality standards that they have learned. For example, facility staff report that Coartem is the only drug on the shelf and consequently is overused and even given to patients with no malarial symptoms, so patients don't feel their visit was useless. Similarly, health post staff in Luanda said they wanted to follow malarial treatment protocol that requires testing before treatment, but due to stock-outs of the rapid tests they felt forced to prescribe Coartem only based on clinical symptoms.

In 2010, MINSA continues to define the solution as eliminating the delays in the procurement and distribution of essential drug kits. The team recommends redefining the objective as ensuring a consistent supply of essential medical products in primary care facilities and looking at different solutions that take advantage of the new medicines policy and new systems to manage the supply. Four specific opportunities emerge.

Opportunity 1: Increase Access, Equity and Sustainability through Private Financing and Supply Chains

In contrast to the chronic stock-outs in the public sector, many medical products are readily available in the private sector and people are paying for them. This suggests that solutions may be explored that take advantage of private financing but are more affordable, assure quality, and are responsive to community needs. Two options are discussed below, revolving drug funds and social marketing, but there are others that may be explored for appropriateness in the Angolan context (Management Sciences for Health 2007).

Revolving Drug Funds (RDFs) have many different models. They can be established at the national, district, community, or even at the facility level. They may be stand-alone or linked through a network depending on the system for purchasing, financial management, and governance. The basic model is that an initial seed capital investment is granted to the RDF either as cash to purchase an initial stock of medical products or as an in-kind donation of products. Revenues from the sale of these products are used to replenish the stock. Product pricing and financing are generally defined by the cost recovery target and may or may not be designed to include subsidies for poorer communities. RDF by-laws govern issues such as the mix of products and how to use any surplus. For example, the surplus can be invested to improve RDF operations or subsidize products for the poor. Products may include more than essential medicines, such as hand soap, bed nets, oral re-hydration solution, or point-of-use water treatment. A guiding principle of RDFs is local level responsibility for the management of the fund with participation of the community. This makes it a particularly interesting model for Angola to consider, as it would address concerns regarding better governance in the management of medicines.

Evaluations of public sector RDFs have been documented in Ghana, Cameroon, Benin, Zimbabwe, and Nigeria (Khalafalla Mohamed Ali 2009). RDF experiences show the importance of good design and lessons in financial management: 1) prices must be set at or above true replacement cost, 2) prompt payment to make funds available for replenishment of drug stocks, 3) program expansion in line with adequate capital funds, 4) prevention of theft and deterioration of drugs, and 5) reserve funds or other strategy to prepare for price increases due to inflation or exchange rates. Community engagement is often part of the design to promote transparency and accountability as well as to ensure that local level needs are addressed. Although there is limited evidence, RDFs and other cost recovery schemes have been criticized for reducing health facility utilization.

Different social marketing models can be explored to take advantage of existing private sector supply systems and enhance the availability of specific essential medical products beyond traditional items such as mosquito nets, condoms and water purification systems. For example, USAID/PMI has been piloting the sale of Coartem in private drug shops and pharmacies in Huambo province. In this model, registered drug shops can purchase subsidized blister packs of Coartem for children and resell them for a modest profit. The Coartem is currently available to PMI's implementing partner, Mentor, free of charge through PMI. The revenue gained from the sales to the pharmacies is used to pay for the cost of repackaging the blister packs to distinguish them from the public sector supply. Although there are still some questions about the actual cost of the operations, the pilot in Huambo has demonstrated that there is a demand for Coartem even in a town where the product has not experienced any stock-outs in the public health facilities. It is expected that this intervention will be scaled-up nation-wide with direct support from Novartis.

Opportunity 2: Strengthen MINSA Regulatory and Enforcement Capacity to Assure Access to Quality Medicines

Increasing access to medical products is only meaningful if the products are of assured quality in both the public and private sectors. Key components of a quality assurance system have been created within the structure of the DNME and progress has been made in developing the capacity of staff and systems to make these components fully functional. This is likely to be a prolonged process, however, involving the development of protocols, procedures and information systems to support regulations and their enforcement. Investments will be required for training and equipment to support implementation at the provincial level. While MINSA has already begun to receive some assistance from its international partners, the scope is such that there will be many opportunities for support to make the policy operational at all levels of the system. The DNME could benefit from having a focal point that ensures there is a strategic and coordinated approach to making investments in this area.

Opportunity 3: Promote Appropriate Drug Use and Contain Antimicrobial Resistance to Improve Quality, Efficiency, and Sustainability

The results from facility-based assessments suggest that overprescribing is not an obvious problem in Angolan facilities. However, the irregular and unpredictable supply of medicines promotes inappropriate use of those that are available (e.g., dispensing Coartem for non-malaria patients) and/or patients purchasing inappropriate medicines from the private sector. Currently, the capacity to evaluate medicines use at the facility level is extremely limited. The need is greatest in hospital settings where more and more potent medicines are prescribed. Hospital-based pharmacy and therapeutics committees (PTCs) have an important role in not only ensuring that prescribing practices adhere to treatment protocols, but also monitor the containment of antimicrobial resistance, an increasing concern for HIV/AIDS and TB programs. Mechanisms to communicate important information about potential problems related to medicine use, including adverse effects could be designed and built in over time by linking facility and provincial level PTCs to national level authorities.

In addition to facility-based interventions, there is an immediate opportunity to advocate for the containment of resistance through community based interventions. This may include targeted IEC/BCC campaigns and stimulation of consumer protection initiatives. Such an initiative should seek to leverage from various programs such as malaria, HIV/AIDS, and tuberculosis that all share a common concern about sustaining the effectiveness of their first-line medical treatments for as long as possible by containing resistance.

Opportunity 4: Strengthen Management Capacity through Improved Inventory Information Systems for Efficiency and Cost Effectiveness

Regardless of the design of the supply chain, access to reliable and timely data on stock availability at each level of the supply chain is indispensable for timely distribution and effective procurement. This includes information systems that can generate key indicators for monitoring stock movement as well as for making decisions regarding the appropriate movement of stock to minimize losses and prevent stock-outs. Currently, the distribution system is not secure and not able to manage complex inventory movement, which is why many vertical programs have opted for managing their own parallel distribution systems. Although transportation services are already contracted out, according to the DNME, a study has been conducted that demonstrates that there are no significant cost savings that can be expected by contracting out these functions. As a result, a plan was developed to construct new warehouses with a “state of the art” information system that links regional warehouses with provincial stores. Although the specifics of this plan were not available at the time of this assessment, we hope that there will be sufficient transparency in the process of determining an appropriate design and testing of this system that will generate critical inventory management performance measures that lend themselves to greater accountability and transparency. Given the importance of an effective supply chain, all stakeholders should be engaged and consulted in the design, testing, and implementation.

5.3 ADDRESSING THE HUMAN RESOURCES ISSUE

There is plenty of documentation and acknowledgement that human resources – the lack of skilled personnel and their poor distribution – is a major barrier to the provision of quality health services in Angola. However, it is important to remember that along with this challenge, there are significant opportunities that should be explored:

1. The salaries of health workers are competitive and generally paid on time. This is an essential foundation to a functioning health workforce, which is already in place. The task of “upgrading” virtually an entire workforce by providing training and follow-up to increase their skill level is indeed daunting. Yet there appears to be consensus on the need to focus on the intermediate-level técnicos, and there are interesting models emerging for training, continuous education and supervision (e.g., master trainers at health facilities);
2. The government of Angola’s contracting of foreign doctors to assuage the physician shortage was cited several times as an opportunity to strengthen the in-country training capacity. For future contracts, MINSA could specifically include capacity-building as a hiring criteria (e.g., include a requirement for training experience) and as a formal part of the doctors’ scope of work in the country. The need to improve the screening process of foreign hired doctors was cited by many key informants, and the capacity-building aspect should be part of a larger effort to improve this system;
3. Regarding the allocation and retention of skilled workers in rural areas, the decentralization to the district level could help improve the current inequity if the elaboration of the “personnel table” (quadro de pessoal) that determines the number of health workers needed is also pushed down from the province to the district level. This would allow for less averaging and a more specific picture of the human resource shortages and overabundances at the district level; the districts are also in a better position than the province to assess the situation at the facility-level. The poor distribution of health workers is not a challenge that is unique to Angola. There are many strategies that have been used in other countries to incentivize service in rural areas (WHO Bulletin 2010), many of which were discussed in the stakeholder workshop. For example: requirement of service time in rural areas after graduation, scholarships for serving a period of time in rural areas, higher salary or bonus, and attractive lodging options. It is essential that MINSA addresses this specific issue and takes the lead in creating the right incentives for the Angola context. In facilities with overabundance of health workers, their management needs to be improved, so that these resources are at least used efficiently. For example, adjusting the facility’s operating hours and setting clearly-defined shifts for staff that ensures coverage of all essential services and minimizes unproductive time. The Luanda DPS has some experience with this strategy;
4. The district health strategy’s focus on integration of services also presents a major opportunity for improving human resources and therefore service delivery. All of the training and capacity building that needs to take place in the next few years should be in line with the integration strategy and contribute to increasing the breadth of primary health care skills of existing health workers. The revision of pre-service training curricula should also be done through an “integration lens” (it came up in the stakeholder workshop that currently new graduates of nursing and medical schools are not familiar with the essential health services package);
5. Finally, the strong interest on the part of donors to address the human resources issue could act as the catalyst to go beyond plans and strategies, into results-oriented action. USAID has already indicated upcoming support through the Capacity Project, and the WHO is assisting MINSA in developing its new human resources strategy. Coordination will be crucial to ensure that there is no duplication of efforts and that instead, a unified, and coherent strategy is developed and supported by all stakeholders.

5.4 INTEGRATION OF SERVICES AT THE DISTRICT LEVEL

MINSa defines its district health strategy as “...the basic structure of delivery of health services that are offered in an integrated form...” (MINSa 2008) putting service integration at the heart of the strategy. This is not a new goal for Angola as the country has tried for years to implement IMCI. However, stakeholders agree that the vertical national programs and vertical donor funding, combined with weak capacity at the local level have been obstacles to service integration. Also, it was noted that there is no incentive for a primary health care worker to expand his/her skill set. In fact, he/she may feel less specialized and likely have to attend more patients.

There is reason for renewed enthusiasm, including broad support for the district health strategy, vertical donors such as the Global Fund, the Global Alliance for Vaccines and Immunizations (GAVI), and PEPFAR officially embracing health system strengthening and service integration, and a growing consensus that fragmented, duplicative systems for information, training, supervision, and procurement have yielded suboptimal results or in the case of good results, concern that they are not sustainable. In addition to the clinical reasons for promoting stronger linkages and integration between vertical services, such as co-infection (HIV/TB, and HIV and malaria), it is thought that integration can employ scarce human and infrastructure resources more efficiently in terms of a wider range of services available and more services delivered per patient visit.

Six areas of advice and ideas were identified:

National Programs/Institutes: Refine their scope and role to focus on strategy, national IEC efforts (e.g., promotion of healthy behaviors, including appropriate health care seeking behaviors), technical orientation (e.g., promotion of appropriate up and down referral systems for treatment, care and support depending on the patient’s entry point), monitoring, and evaluation. National programs should provide political support for integrated training, supervision, procurement, and information systems at the service delivery levels. Leave implementation to the service delivery levels;

Human Resources: As mentioned above, proposed reforms and investments should purposefully support integrated service delivery at the district level, including motivating health workers to expand their skills and work load;

Supervision: Currently there are supervision teams consisting of staff from the national programs from the DNSP. Instead, stakeholders suggest that integrated supervision be handled at the provincial level by the DPS. This will require funds for transportation out to district facilities. An even more decentralized model is to have a “master trainer” in each district that is trained in all vertical program areas and knows how to train health workers. USAID’s SES project is piloting master trainers in several provinces;

Information Systems: GEPE seeks to harmonize vertical forms and databases and the Health Metrics Network is engaged to assist. The forms and database for recording patient visits (consultations) are already unified, but not all facilities submit accurate, and timely data. Progress on making an integrated information system operational requires improving health worker training and supervision. For example, HIS training should be integrated with clinical and management training so that participants understand how to use data for clinical and managerial decisions. Integrated supervision should make use of HIS data and reinforce good HIS practices for data collection, analysis, and use.

Medical Supplies Management:

- Section 5.2 already discusses the opportunity (number 4) presented by the planned construction of new warehouses including a state of the art information system to create a single integrated inventory management program;
- Distribution of preventive commodities (especially mosquito nets, condoms and other family planning products) through other services; for example family planning products distributed through Preventing Mother-to-Child Transmission of HIV (PMTCT) programs or mosquito nets distributed when vaccines are provided;
- Increased opportunities to synergize for clinical diagnosis and rational use of laboratory services and supplies such as rapid diagnostic tests (malaria and HIV).

Community Services: Clear imperative for integration of home-based treatment and community case management for TB treatment, antenatal services of HIV positive pregnant women (PMTCT), the Integrated Management of Adult Illnesses (IMAI), and IMCI. Priority need for successful models and funding of CHWs (see below).

5.5 REACHING COMMUNITIES AND HOUSEHOLDS

There is consensus regarding the need to go beyond the “fixed network” of facilities and reach the community and households with cost-effective interventions related to water, hygiene, family planning, nutrition, neonatal care, use of ITNs, and patient adherence to treatment of TB and AIDS.

UNICEF noted that still a majority of Angolans have limited access to services. Similarly, the World Bank project document notes that, “....60 percent of the population does not have reasonable access to health care. Most people still have to walk more than one hour to reach a health facility.” Several experiences have been and are being tried (Box 8).

This section discusses two strategies: community health workers and household production of health.

Community Health Workers: The government’s district health strategy refers to community agents (*Agentes Comunitários*) as the “fundamental element of interaction between the community and health services” and proposes advocating with provincial and district authorities to employ the community agents. Shifting the responsibility to the district, in addition to the facility costs and management, seems unlikely to succeed in the short term. In fact, there is little consensus or clarity on exactly what CHWs should do, how they should be organized, and if/how they should be paid;

Given the variety of experiences in Angola so far (see Box 8), a thorough evaluation is suggested to review the performance of CHWs, results in access and coverage, and costs.¹⁵ Indeed, information from supervision gives a mixed image. On one hand, community and household practices are improving (but there is not necessarily a link with increased number of CHWs), on the other there is empirical evidence of a high turn-over of CHWs. These observations raise questions as to whether resources invested in training and supervising CHWs could instead be put to better use in improving access and outreach of health services, at least in urban and peri-urban areas; and alternative channels for improving household practices (churches, media, etc...). Additionally, the low rate of skilled birth attendance and

¹⁵ Comments adapted from review comments from Dr. Koen Vanormelingen

the existence of TBAs supported by the Ministry of Family require this latter cadre to be included in any assessment of community-based health resources. UNICEF has agreed with the government to support an assessment in 2010 and the terms of reference are being finalized.

At the stakeholder workshop, the team proposed that the lack of clarity regarding how to employ CHWs was an opportunity to test different approaches, and could be valuable and appropriate during the next five years as the district strategy is rolled out. To maximize the value of experimentation, the team recommended that MINSA, district and provincial authorities, and partners systematically monitor and share lessons, or even consider formal evaluation design. However, some government representatives expressed the need for immediate regulation to standardize the approach to CHWs and are hesitant to experiment.

Given the high cost of living in Angola, the team suggests looking at models from other countries that pay CHWs such as BRAC, one of the largest NGOs in the world that employs CHWs in Bangladesh (Chowdury 2009), Tanzania, and Uganda and Partners in Health in Haiti and Rwanda (Partners in Health Online Publications).

Household Production of Health¹⁶:

Health Systems 20/20 appreciates that people are at the center of the health system, as patients, consumers, civil society, payers, and producers of health through their behavior. The promotion of appropriate self-care, preventive and curative, cannot be overlooked as a strategy to improve health outcomes that complements Angola's investment in facility-based services. Ample evidence exists (Darmstadt et al. 2005 and Kumar et. al 2008) to show the impact of household practices such as hand washing and exclusive breast-feeding, and use of commodities such as condoms, insecticide nets, iodized salt, and point-of-use water treatment. These inexpensive practices and products are highly cost-effective and at least as important to improve health outcomes as adequate access and utilization of health services.

The district health strategy's attention to the role of households is limited to saying that CHWs will be responsible for improving household capacity to employ good health practices in prevention, nutrition,

Box 8: Different Ways to Reach the Community

- Angola's vaccination campaigns rely on community "activistas" to promote participation. Vaccine coverage has increased to an estimated 83 percent;
- In 2008-09, MINSA trained thousands of CHWs in Huila and Luanda. However, they were not put on the official payroll and their salary payment stopped several months ago;
- An external advisor suggested that volunteer community health workers in Huambo be paid. The volunteers received payment for several months, but after the payments stopped some workers quit;
- Volunteer health workers associated with NGO or religious organizations, such as HIV/AIDS community health workers based at Hospital Divino Beneficio;
- Community residents volunteer on Water Management Committees established with the support of donors and NGOs in response to the critical lack of affordable, potable water;
- The National Child Council is interested in community workers to advance initiatives for children that would be broader than health;
- The new World Bank project intends to support scaling up mobile teams by providing vehicles and motorcycles, and community health workers with training, uniforms, and materials.

¹⁶ Adapted from review comments sent by Dr. Koen Vanormelingen

water, and sanitation. As mentioned above, Angola could use alternative channels for improving household practices such as churches, the media, and water management committees.

5.6 DONOR COORDINATION

The district health strategy offers a clear basis for donor coordination. New health projects from the World Bank and EU explicitly reference the strategy. There are many opportunities for improved efficiencies and results:

- Shared results framework based on the objectives and targets of the district health strategy;
- Shared funding of national surveys or studies;
- Coordination in terms of where donors work/invest geographically (the World Bank and EU projects will work in different provinces);
- Coordination of central level efforts, for example multiple donors propose assistance (e.g., assessments, studies, plans) to improve HR management and avoid the risk of duplication;
- Coordination at the provincial and district levels when more than one donor is present;
- Sharing lessons when different approaches are being tested, as may be the case for CHWs.

However, there continues to be no formal body or forum for health sector donors. In the short run, partners should take advantage of existing bodies such as the ICC and CCM. Donors might also consider regular meetings among themselves for information sharing until MINSA establishes an alternative. In the long run, a formal donor coordination body should be established informed by the GEPE study of experiences in other African countries.¹⁷

5.7 BEYOND THE HEALTH SECTOR

As mentioned in the Health Status section of this report, there are a number of factors that are beyond what is considered the health system or sector, but that nonetheless have a strong impact on the health outcomes of the population. There is increasing recognition among the development community and emerging evidence that holistic, cross-sector approaches can deliver program results more efficiently and successful models are beginning to emerge (Pielemeier 2007). Although this assessment focuses on the health system, it is worthwhile noting a few opportunities for cross-sector coordination or collaboration in Angola that have the potential to deliver significant results in health:

Leveraging Environmental Health to Promote Sustainable Improvements in Health System Performance

Many environmental health issues relate directly to health-specific Millennium Development Goals 4, 5, and 6 that are linked to child mortality, maternal health, and combating vector-borne diseases. The traditional environmental health related to poverty and lack of development (e.g., inadequate water supply and sanitation), and the modern hazards caused by development (e.g., pollution and agro-

¹⁷ At the stakeholder workshop, GEPE announced that they were conducting a review of donor coordination experiences in other African countries.

industrial chemicals and waste) are significant problems in Angola. As donors and stakeholder groups have been working to address these, many lessons have emerged that can inform the effort to improve the performance of the rest of the Angolan health sector around governance and stewardship, and equity and finance.

One lesson or best practice that has emerged is the potential for change that can be harnessed through the establishment of community-based organizations. Such organizations have been able to create awareness of issues of public concern and to generate both a demand for solutions as well as the creation of appropriate solutions. For example, access to safe water in particular has been a priority for the GOA at least since the end of the war. With support from donors such as DFID and UNDP, programs have been established to support this goal. The more successful programs have been those that have a strong local community orientation and in which residents establish successful working relationships with local authorities. Through community water committees, residents have been able to influence the provision of other basic services, such as power, sewerage, and even more. For example, LUPP since 1999¹⁸ has provided clean water at substantially reduced rates for residents, but it also provides microfinance and business development services. For example, the program has enabled the creation of an independent, financially sustainable Angolan organization called Kixi-Credito, the first non-bank microfinance institution in Angola.

Related to the lesson of the value of organizing around an issue of common concern, these programs also generated data supporting the idea that there is a sound basis for implementing cost recovery programs, that is, community members are generally willing to contribute toward the cost of providing services in Angola, even when those services have been deemed a basic right to all citizens (Cain and Mulega 2009). This experience suggests that patients may be open to the possibility of cost sharing for their services, providing the services they receive are deemed relevant for their needs.

Supporting Livelihoods and Agricultural Development with a Link to Food Security, Nutrition, and Health

Malnutrition is the main associated cause of mortality in Angola, and yet the country's vast potential for agriculture is still largely untapped. USAID already has programs that support small and medium scale farmers. As the government of Angola and donors continue to work on developing the agriculture sector, there is an opportunity to ensure a strong link to food security and nutrition, so that as the agriculture sector grows, so does sustainable access to nutritious foods by the populations in most need.

Opportunities should also be sought to incorporate healthy living messages into other economic development and livelihood efforts. For example, the SPREAD Project in Rwanda, a USAID Agribusiness Project, has added a health promotion component to its work with coffee growers (Thanxton 2009).

Strengthening the Education Sector in Angola

The positive link between maternal education and maternal and child health outcomes has been well established for decades. Along with virtually every sector, the education sector was extremely weakened during the civil war in Angola. Although this assessment did not examine the status of the education system in Angola, nor current efforts to improve it, it is worth noting that investment in this sector could yield significant health results in at least two ways: by improving girls' and women's

¹⁸ The Luanda Urban Poverty Program was funded by DFID and implemented by Save the Children UK, Care International, Development Workshop and One World Action.

education status, and therefore improving their health behaviors and their and their children's health outcomes; and by creating a better educated health workforce, providing a stronger foundation to improve Angola's human resources for health.

5.8 PROMISING ENVIRONMENT

There is an incipient, but growing sense of state accountability to patients and community fueled by the parliamentary elections in 2008, decentralization to districts, and upcoming presidential elections in 2012. The district health strategy offers clear direction, is more pro-poor and focused on maternal child health. Some aspects of the strategy are clear and standardized (e.g., fixed delivery system including referrals between levels, basic benefits package, need for integrated supervision and information system at the district level). Other aspects are not clear and could benefit from experimentation and creativity such as CHWs and district health financing. There is broad agreement on the problems and even the solutions in many cases, but not always on "how" at an operational level. Public sector leaders do not always feel empowered to act. There is a preoccupation with planning and regulating, as opposed to implementing.

ANNEX A: INDICATOR TABLE

Health Systems Data/Angola	Source of Data	Country Level Data Angola	Year of Data	Average Value of Regional Comparator [1] Sub-Saharan Africa	Year of Data	Average Value for Income Group Comparator [2], [3] Lower Middle Income	Year of Data
Core Module							
Population, total	WDI-2009	16,948,673	2007	17,020,755	2007	68,285,669	2007
Population growth (annual %)	WDI-2009	2.34	2007	2.26	2007	1.41	2007
Rural Population (% of total)	WDI-2009	44.2	2007	61.85	2007	52.47	2007
Urban Population (% of total)	WDI-2009	55.8	2007	38.15	2007	47.53	2007
Population ages 0-14 (% of total)	WDI-2009	46.12	2007	42.09	2007	33.62	2007
Population ages 65 and above (% of total)	WDI-2009	2.41	2007	3.33	2007	5.26	2007
Contraceptive prevalence (% of women ages 15-49)	WDI-2009 IBEP 2008	6.2 18	2001 2008	15.78	2001	27.4	2007
Fertility rate, total (births per woman)	WDI-2009	5.8	2007	4.89	2007	3.17	2007
Pregnant women who received 1+ antenatal care visits (%)	UNICEF_Chidinfo.org IBEP 2008	80 69	2006 2008	79.26	2006	86.05	2006
Pregnant women who received 4+ antenatal care visits (%)	UNICEF_Chidinfo.org	--	--	44.71	2006	62.2	2006
Prevalence of HIV, total (% of population aged 15-49) [4]	UNAIDS 2008 UNGASS 2010	2.1 2.0	2007 2010	5.75	2007	2.04	2007
Life expectancy at birth, total (years)	WDI-2009	42.7	2007	53.21	2007	65.86	2007
Mortality rate, infant (per 1,000 live births)	WDI-2009 IBEP 2008	115.7 150	2007 2008	79.05	2007	40.66	2007
Mortality rate under-5 (per 1,000)	MICS WDI-2009 IBEP 2008	250 158 195	2001 2007 2008	124.93	2007	54.53	2007
Maternal mortality ratio (per 100,000 births) [5]	WDI-2009	1,400.00	2005	832.16	2005	319.33	2005
GDP per capita (constant 2000 US\$)	WDI-2009	1,265.52	2007	1,003.21	2007	1,396.79	2007
GDP growth (annual %)	WDI-2009	21.13	2007	5.29	2007	6.7	2007
Per capita total expenditure on health at international dollar rate	WHO	71	2006	147.78	2006	261.47	2006

Health Systems Data/Angola	Source of Data	Country Level Data Angola	Year of Data	Average Value of Regional Comparator [1] Sub-Saharan Africa	Year of Data	Average Value for Income Group Comparator [2], [3] Lower Middle Income	Year of Data
Private expenditure on health as % of total expenditure on health	WHO	13.4	2006	48.94	2006	42.87	2006
Out-of-pocket expenditure as % of private expenditure on health	WHO	100	2006	78.02	2006	85.6	2006
Gini index	WDI-2009	58.64	2000	47.35	2000	47.69	2006
Adult literacy rate (%)	WDI-2009	67.41	2001	71.17	2001	87.37	2007
	UNESCO	67.4	2001	71.18	2001	85.61	2007
Population with sustainable access to improved drinking water sources (% total)	WHO IBEP 2008	51 42	2006 2008	66.36	2006	82.4	2006
Improved sanitation facilities (% of population with access)	WDI-2009 IBEP 2008	50 60	2006 2008	32.39	2006	63.21	2006
TB prevalence, all forms (per 100 000 population)	WHO	294	2007	437.09	2007	212.68	2007
Percentage of children under five with low height for age (stunting)	WHO	50.8	2001	41.42	2001	37.35	2006
Percentage of children under five underweight	WHO UNICEF	27.5 16	2001 2007	24.9	2001	23.08	2006
Measles coverage	WDI-2009	88	2007	75.74	2007	86.89	2007
Governance Module							
Voice Accountability - Point Estimate [6]	WB-Governance Indicators	-1.07	2008	-0.54	2008	-0.41	2008
Voice and Accountability - Percentile Rank	WB-Governance Indicators	17.3	2008	33.17	2008	37.09	2008
Political Stability - Point Estimate [6]	WB-Governance Indicators	-0.43	2008	-0.56	2008	-0.44	2008
Political Stability - Percentile Rank [7]	WB-Governance Indicators	29.6	2008	33.33	2008	35.88	2008
Government Effectiveness - Point Estimate [6]	WB-Governance Indicators	-0.98	2008	-0.78	2008	-0.56	2008
Government Effectiveness - Percentile Rank [7]	WB-Governance Indicators	13.7	2008	26.77	2008	33.35	2008
Rule of Law - Point Estimate [6]	WB-Governance Indicators	-1.28	2008	-0.74	2008	-0.52	2008
Rule of Law - Percentile Rank [7]	WB-Governance Indicators	7.6	2008	28.99	2008	34.63	2008
Regulatory Quality - Point Estimate [6]	WB-Governance Indicators	-0.94	2008	-0.7	2008	-0.54	2008
Regulatory Quality - Percentile Rank [7]	WB-Governance Indicators	16.9	2008	29.29	2008	33.69	2008
Control of Corruption - Point Estimate [6]	WB-Governance Indicators	-1.22	2008	-0.62	2008	-0.56	2008

Health Systems Data/Angola	Source of Data	Country Level Data Angola	Year of Data	Average Value of Regional Comparator [1] Sub-Saharan Africa	Year of Data	Average Value for Income Group Comparator [2], [3] Lower Middle Income	Year of Data
Control of Corruption - Percentile Rank [7]	WB-Governance Indicators	6.2	2008	31.35	2008	33.9	2008
Health Financing Module							
Total expenditure on health as % of GDP	WHO	2.7	2006	5.3	2006	6.08	2006
Per capita total expenditure on health at average exchange rate (US\$) [8]	WHO	71	2006	71.8	2006	106.91	2006
Government expenditure on health as % of total government expenditure	WHO	5	2006	9.59	2006	9.57	2006
Public (government) spending on health as % of total health expenditure	WHO	86.6	2006	51.06	2006	57.13	2006
Donor spending on health as % of total health spending	WHO	7	2006	22.39	2006	11.13	2006
Out-of-pocket expenditure as % of private expenditure on health	WHO	100	2006	78.02	2006	85.6	2006
Out-of-pocket expenditure as % of total expenditure on health	WHO	13.4	2006	39.05	2006	37.51	2006
Private expenditure on health as % of total expenditure on health	WHO	13.4	2006	48.94	2006	42.87	2006
Service Delivery Module							
Number of hospital beds (per 10,000 population)	WHO	1	2005	10.79	2005	15.73	2005
Percentage of births attended by skilled health personnel	WDI-2009 IBEP 2008	47.3 48	2007 2008	59.15	2007	75.22	2007
DTP3 immunization coverage: one-year-olds (%)	WHO	83	2007	85.22	2007	88.38	2007
Contraceptive prevalence (% of women ages 15-49)	WDI-2009 IBEP 2008	6.2 18	2001 2008	15.78	2001	27.4	2007
Pregnant women who received 1+ antenatal care visits (%)	UNICEF_Chidinfo.org IBEP 2008	80 69	2006 2008	79.26	2006	86.05	2006
Life expectancy at birth, total (years)	WDI-2009	42.7	2007	53.21	2007	65.86	2007

Health Systems Data/Angola	Source of Data	Country Level Data Angola	Year of Data	Average Value of Regional Comparator [1] Sub-Saharan Africa	Year of Data	Average Value for Income Group Comparator [2], [3] Lower Middle Income	Year of Data
Mortality rate, infant (per 1,000 live births)	WDI-2009 IBEP 2008	115.7 150	2007 2008	79.05	2007	40.66	2007
Maternal mortality ratio (per 100,000 births) [5]	WDI-2009	1,400.00	2005	832.16	2005	319.33	2005
Prevalence of HIV, total (% of population aged 15-49) [4]	UNAIDS 2008 UNGASS 2010	2.1 2.0	2007 2010	5.75	2007	2.04	2007
Children under five sleeping under insecticide-treated bed nets	WDI-2009 IBEP 2008	17.7 16	2007 2008	14.3	2007	17.34	2006
Children under five years with diarrhea receiving oral rehydration	WDI-2009	31.7	2001	35.72	2006	40.63	2006
ART coverage among people with advanced HIV infection (%)	WHO	16	2006	21.88	2006	21.55	2006
Human Resource Module							
Physicians (density per 10,000 population)	WDI-2009	0.8	2004	2.06	2004	4.24	2004
Nursing and midwifery personnel density (per 10 000 population)	WHO	13.5	2004	22.98	2004	22.78	2004
Pharmacists (density per 10,000 population)	WHO	--	--	3.75	2004	3.8	2006
Lab technicians (density per 10,000 population)	WHO	1	2004	2.21	2004	3.42	2004
Pharmaceutical Module							
Total expenditure on pharmaceuticals (% total expenditure on health)	WHO-The World Medicines Situation-2004	20.3	2000	27.52	2000	26.04	2000
Total expenditure on pharmaceuticals (per capita at average exchange rate) in US\$	WHO-The World Medicines Situation-2004	5	2000	9.87	2000	14.48	2000
Government expenditure on pharmaceuticals (per capita at average exchange rate) in US\$	WHO-The World Medicines Situation-2004	1	2000	6.12	2000	6.05	2000
Private expenditure on pharmaceuticals (per capita at average exchange rate) in US\$	WHO-The World Medicines Situation-2004	4	2000	6.53	2000	10.88	2000

Health Systems Data/Angola	Source of Data	Country Level Data Angola	Year of Data	Average Value of Regional Comparator [1] Sub-Saharan Africa	Year of Data	Average Value for Income Group Comparator [2], [3] Lower Middle Income	Year of Data
Health Information System (HIS) Module [10] [11]							
Maternal mortality ratio reported by national authorities (Timeliness of reporting, years) [12]	WDI-2009	3-5 years	--	3-5 years	--	3-5 years	--
Mortality rate under-5 (Timeliness of reporting, years) [12]	WDI-2009	0-2 years	--	3-5 years	--	3-5 years	--
HIV prevalence rate in total population aged 15-24 (Timeliness of reporting, years) [12] [13]	UNAIDS 2008	less than 2 years	--	less than 2 years	--	less than 2 years	--
Low birth weight newborns (Timeliness of reporting, years) [12]	WHO	6-9 years	--	6-9 years	--	6-9 years	--
Number of hospital beds (Timeliness of reporting, years) [12] [14]	WHO	2-3 years	--	2-3 years	--	2-3 years	--
Contraceptive prevalence (Timeliness of reporting, years) [12] [15]	WDI-2009	4 years or more	--	4 years or more	--	4 years or more	--
Percentage of surveillance reports received at the national level from districts compared to number of reports expected (Completeness of reporting,%) [16]	WHO/UNICEF Joint Reporting Form on Immunization	90% or more	--	90% or more	--	90% or more	--

ANNEX B: DONOR MAP OF PROGRAMS IN ANGOLA HEALTH SECTOR

Donor	Summary of Current Projects	Timeline	Funding	Future Health Projects	Project Location
Multilateral Donors/Organizations					
European Community	<p>Health Sector Support Program (PASS) funded from the European Development Fund, assisted GEPE Mapas Sanitarios for five provinces in 2007; Local Health Systems in Angola to translate the Mapas into provincial development plans for the same 5 provinces.</p> <p>2008-2013 EC-Angola Country Strategy Paper (CSP): Interventions under human and social development: Train human resources in the social sectors, support decentralization (MIS, planning, and budgeting, and spending); community participation in the management of primary services; improve synergies between health, education and water/sanitation; financing for equipment and infrastructure at the district level.</p>	<p>2004 – 2010</p> <p>2008-2013</p>	€ 21M (US\$ 28M)	PASS II 2010-2014: Provincial Development Plans and District Health System Revitalization € 25M (US\$ 33.3M)	PASS II: National and 5 provinces: Luanda, Bié, Huambo, Huila, and Bengela
Global Fund	Round 4 for HIV/AIDS supports capacity development of the INLS national and provincial, capacity development of NGOs to manage ART, and equipping 99 health centers. \$40M balance remaining to spend by September 2010 unless a no-cost extension is approved. Round 7, a 5-year \$78 million malaria grant is paying for bed nets, anti malarial drugs, diagnostics, and human resources; including National Program Officers at central level and in each province (formerly funded through WHO).	Now – Sept 2010	\$40M HIV/AIDS US\$78M Malaria	4 applications for Round 10 proposal are in process. Technical Working Groups are established for each application.	National

Donor	Summary of Current Projects	Timeline	Funding	Future Health Projects	Project Location
GAVI	Pentavalent and correspondent injection supplies are guaranteed by GAVI until 2010. In 2007 the Pentavalent vaccine was introduced in all districts of the country as a total substitution of DTP.	2003-2010	Penta vaccines since 2007 plus US\$17M disbursed from 2003 to 2007.	Penta vaccine donations projected through 2015. Co-payment from Angola to begin in 2011.	National – EPI
UN Agencies	<p>The United Nations Development Assistance Framework (UNDAF) agreement signed with the GoA in 2009, proposes a budget of \$31M/year for health systems strengthening, M&E, HIV prevention among MARPs, youth and general population; gender equality, human rights, stigma reduction, and other related areas.</p> <p>Joint Country Support for Accelerated Implementation of Maternal and Newborn Continuum of Care: harmonize approaches at the country level among WHO, UNICEF, and World Bank.</p>	<p>2010 – 2014</p> <p>2008 - forward</p>	<p>US\$ 31M per year under the UNDAF</p> <p>Not specified</p>		National
UNDP	<p>Decentralization and Governance Project 2008-2010 strengthens the capacity of provinces and district administrations in five key areas: Enhancing the institutional, organizational, technical and management capacities of District Administration for effective service delivery; Strengthening planning and budgeting in district administration; Enhancing financial management for fiscal decentralization; Decentralization for enhanced community participation, especially woman in local governance; Strengthen mechanisms for efficient coordination, monitoring and evaluation.</p> <p>Non-health: Recently completed projects in ITC (internet for districts through local NGOs) and micro-finance.</p>	Various projects with different timelines	Decentralization Project US\$ 9.45M over 3 years. Co-funded by Dfid and Coop Espanhola	Proposed extension of the Decentralization Project to 2012.	Decentralization Project is in 15 districts from 5 provinces (Bie, Malanje, Bengo, Kwanza Norte and Uige).

Donor	Summary of Current Projects	Timeline	Funding	Future Health Projects	Project Location
UNDP-GF	Improve HIV labs at national level, support INSL to clean and analyze sentinel surveillance data, support GF proposal development, support provincial committees, train female sex workers on HIV prevention, condom procurement and distribution (with INLS), support prevention efforts aimed at youth, PLWA, and most-at-risk populations; support HIV education for teachers and youth in and out of school; train providers and INSL on hemotherapy and bio-security; Technical Assistance on procurement, logistics, distribution of testing and treatment supplies; support MOH to deliver services to orphans and vulnerable children through civil society.	On-going	Part of the US\$ 31M per year from 2010-2014 (see above)		National
UNICEF	<p>Angola's National Plan for Children is the basis for UNICEF's programs – health and non-health. The UNICEF's main counterpart body is the National Council for Children consisting of 12 vice-ministers.</p> <p>3 rounds of the Multiple Indicator Cluster Survey (1996, 2001, and 2008) MICS, is a UNICEF-supported census designed to evaluate the well-being of women and children. Angola's third MICS was conducted in all of its 18 provinces in 2008 and included detailed malaria and expenditure modules. Results not public yet.</p> <p>UNICEF consultant at the Cabinet level and provides technical assistance to district health teams in 16 districts.</p> <p>Accelerated Child Survival Development (ACSD) combines health, water, and HIV responses focusing on women and children.</p>	<p>2006</p> <p>2007</p> <p>2008</p> <p>2009</p>	<p>Health, Nutrition, HIV: US\$ 16.5M; WASH: US\$ 5.7M</p> <p>Health, Nutrition, HIV: US\$ 19M; WASH: US\$ 8.5M</p> <p>Health, Nutrition, HIV: US\$ 21.2M; WASH: US\$ 6.3M</p> <p>Child Survival (includes WASH): US\$ 21.5M; Humanitarian Action Report (HAR): US\$ 2M</p>		National

Donor	Summary of Current Projects	Timeline	Funding	Future Health Projects	Project Location
	<p>HIV/AIDS: Support for GF proposal development, to update National Strategic (HIV/AIDS) Plan, to Provincial Health Directorates (DPS) and districts in strategic planning and delivering PMTCT+ and AIDS pediatric service, to develop an MCV M&E framework, for NGO project implementation, for interventions targeting youth in and out of school.</p> <p>Humanitarian Action Response (HAR) addressing emergencies such as flooding, cholera, malnutrition; as well as disaster preparedness. Approx. \$2M in 2009.</p>	2010	Child Survival: US\$ 20.6M (10)		
UNAIDS	Prepare data for UNGASS reporting. NASA not done for 2009. Support CCM and GF applications.	Ongoing	Not specified	National Aids Spending Assessment (NASA) analysis of HIV/AIDS expenditures	National
World Health Organization (WHO)	<p>All 3 levels of WHO (Geneva, WHO/Afro, and the local representative) provide assistance. As of 2007, the local office had 189 employees.</p> <p>At the national level, WHO supports elaboration of national health policy and national development plan, M&E. NHA for 2006-08 is expected for July 2010.</p> <p>Guidelines for HIV/AIDS and strengthen capacity of local INLS to monitor drug resistance Child and adolescent health focus as part of district revitalization.</p> <p>Since 2001, local presence in all 18 provinces of a 3-person unit that is the focal point to support the Provincial Health Directorate with infectious disease surveillance and vaccination (EPI) and district revitalization effort.</p>	On-going since 2001 Current Cooperation Strategy is for 2009-2013	US\$ 47.65M/year as of 2007. Up to 90% of funds are from other donors (USG, UK, others)	2009-2013 Strategy has 3 areas: 1. MCH: service provider training, service integration 2. Infectious disease: surveillance, prevention, diagnosis and treatment. 3. Health system management: HR management and formation, SIS and research, medications and technology, financing, donor coordination	National + 18 provincial teams

Donor	Summary of Current Projects	Timeline	Funding	Future Health Projects	Project Location
World Bank	HAMSET Project to control HIV, Malaria and TB is to end June 2010.	2006-11	US\$ 21M	Currently developing Angola's Country Partnership Strategy (all sectors), which will guide its operations 2010-2013.	Project Mangement Unit (PMU) with MINSA NDSP in Luanda
	Health component (US\$8 million) of the Emergency Multi-Sector Rehabilitation Project (EMRP). MHSS (District Health Service Strengthening) – See summary at end of this Annex	2011-2016	US\$ 70M	New health project to support MINSA's District Health Revitalization Strategy.	New project to target 18 districts in 6 provinces: Bengo, Malange, Lunda Norte, Moxico, and Uige
Other	Brazil – capacity building, TA China – infrastructure Cuba – physicians, medical school scholarships Portugal and Spain – part of EU's PASS project	On-going	unknown		

SUMMARY OF THE NEW WORLD BANK DISTRICT HEALTH SERVICES STRENGTHENING PROJECT (MHSS) 2011 – 2016

US\$ 70.8 IDA Loan + US\$ 4.5 million from private company in Angola

Goal: To improve the population's access to and quality of maternal and child health care services.

Rationale: Long-term investment in training and infrastructure is being undertaken by the government. MHSS puts in place a short-term strategy to reach the Millennium Development Goals more quickly.

Three Core Components:

1. Improving service delivery in 18 districts in 5 provinces; approx 1.9 million people (US\$ 56.3 million): Strengthening services at the district level, scaling up outreach (vehicles, motorcycles, teams), community interventions (CHWs), improving obstetrical care (infrastructure, equip, telemedicine), and hospital waste management disposal;
2. Piloting of demand-side incentives (vouchers) to encourage institutional deliveries (US\$ 0.8 million);
3. Strengthening the capacity of the MOH and districts (US\$ 18.2 million)

Strengthening the Capacity of the Department of Planning (GEPE) of the MOH by hiring consultants to support the preparation of:

- Medium-Term Human Resources Development Plan;
- Health Infrastructure Investment Plan and
- Medium-Term Expenditure Framework (MTEF).

Strengthening of Monitoring and Evaluation (M&E):

- Strengthening the M&E capacity of the MOH in the use of the current HMIS;
- Capacity building in data for decision-making at central, provincial, and district level;
- Preparation and conducting of access and quality surveys: Annual rapid KAP survey with WHO (300-500 households in all MHSS target provinces) and rapid Facility surveys (4/districtity) in the 18 target districts;

- Mid-term and final evaluations of the project; and
- Computers, training manuals, and stationery for M&E.

Total E&P: Angola will finance part of the training program, solar kits and the rehabilitation/construction of four delivery rooms in Malange.

Coordination: Collaborate with UNICEF, WHO, and UNFPA on technical and implementation issues.

Management: Steering committee to monitor the progress of the MHSS project: Minister of Health, Director of Public Health, the Director of Planning, the Revitalização Coordinator, and any other member designated by the minister.

ANNEX C: ANGOLA HEALTH SYSTEMS ASSESSMENT WORKSHOP



Angola Health System Assessment Workshop
Tuesday, 20 April 2010

USG agencies and the Angolan Ministry of Health will jointly host a workshop to review initial findings from the 2010 Health System Assessment and discuss recommendations for USG and the MOH as they are developing their strategies for Angola's health sector. This Assessment updates a similar assessment done for Angola in 2005 and, in particular will:

- Review new sources of data that have become available since 2005;
- Identify areas of national progress since the 2005 HSA and successful strategies;
- Identify the continuing challenges to strengthening Angola's Health System, with particular attention to: human resources, health information systems (HIS), commodity security, donor coordination, and translating good planning into action;
- Develop recommendations to help inform the MOH's development of their new health strategy and USG/Angola's integrated health strategy.

Agenda

8:00-8:30	Coffee and registration
8:30 – 9:15	Welcome from MoH and USG Overview of objectives and agenda Introductions
9:15 – 10:30	Presentation of findings: What has changed since 2005? Promising initiatives Recommendations Questions and discussion
10:30-10:45	Coffee break
10:45-11:45	Small group discussion to discuss specific recommendations
11:45 – 12:45	Groups report out
12:45-13:00	Closing
13:00	Adjourn for lunch

Main Discussion Points from Group Work

Group 1 (questions 1-3)

Questions for discussion:

1. *Revitalization of District Health System requires **financing**.*
 - *In the budgeting process, how can districts better influence the budget ceilings established by the MINFIN?*
 - *How to guarantee minimum funding at the district level? How can the RMS, who reports to the District administration, influence this?*
 - *Budget fixed by MINSA and MINFIN based on data*
 - *Advocacy through the DPS*
 - *Financial bonus for districts that make measurable progress towards Revitalization goals (verified independently)*
 - *Advocacy through the district administrator's wife (who is the Head of the Maternal Mortality Auditing Committee)*
2. *Revitalization of District Health System requires **essential drugs**.*
 - *How to guarantee continuous stock of essential drugs?*
 - *How to guarantee quality of products? New mechanisms needed (from registration through post-marketing surveillance)*
 - *How to include the concept of quality in pharmaceutical support?*
3. *Revitalization of District Health System requires **human resources that are***
 - *Skilled*
 - *How to create and maintain an adequate workforce?*
 - *How to make better use of "imported doctors" (and military medical resources) in the training and capacity-building of human resources?*
 - *Motivated*
 - *Public recognition*
 - *Financial bonus*

Main Points Discussed:

- **Financing:**
 - Identify, with civil society, other sources of funding (private);
 - There needs to be:
 - A municipal plan made with data on what is needed
 - Needs defined by the epidemiological scope/perspective
 - Plans made by capable people
 - Participation in civil society pair.
- **Essential Medicines:**
 - Sometimes there is a break in the stock at the district level, but not at the central level, from lack of adequate planning and rational use;
 - Need to minimize risk and do good management:
 - People trained at every level on management of stock
 - There needs to be instruments including lists of stock and list of essential medicines
 - People trained in rational medical use

- This would bring better quantification, not only of consumption, but also epidemiologically
- Just buy what is on the list
- Improve logistics (warehousing and transport).
- **Human Resources:**
 - Better management of the same workers (e.g., Five lab technicians in a facility, but on the day of the visit there were none);
 - There needs to be national political discussion on reproductive health;
 - Redistribution:
 - Suggestion of obligatory work time in rural areas after training
 - Scholarship for working in rural areas
 - Salary/bonus for working in rural areas
 - Lodging for working in rural areas
 - Take advantage of expats (imported doctors) for:
 - Pre-service training
 - Continuous learning
 - Supervision
 - Integrated training – the people could have more options for work;
 - Support of upper level institutes and universities of medicine in other areas and their regulation (Question of the quality of the curriculum);
 - Accreditation (credits) of the continuing education courses as incentive for professional growth;
 - Definition/vision of a career;
 - Evaluation of the people should be more technical; currently it's the same for all public workers (nothing specific to health).

Group 4 (question 4)

Questions for discussion:

4. *Revitalization of District Health System, focused on maternal and child health, requires integration of services.*
 - *How to link vertical funding with a horizontal service delivery? How to demonstrate results to the vertical programs?*
 - *Integrated supervision?*
 - *Harmonized HIS?*
 - *How to maintain a single inventory? Expand the improvement of stock management practices, rational use and pharmacovigilance for essential medicines of all programs?*

Main points discussed:

- **Municipal Level:**
 - Where integration is best functioning, but the following is still necessary:
 - Municipal health plan
 - Integration of HIS
 - Financing of a minimum package
 - Definition of the list of people for implementation
- Suggestion for the **role of the national programs:**
 - Orientation, strategy and evaluation
 - Leave the implementation to other levels, where integration is more obvious

- **Supervision**
 - Supervision plan needed
 - Banner of integrated supervision
 - Teams at the DPS level that receive funds from the programs but conduct activities in an integrated manner
 - Who will do the supervision
 - Before there were supervision teams from DNSP (integrated)
- **HIS**
 - Existing system is very fragmented – necessity of one registry/database:
 - Database of consultations is already integrated – there is already a model (but there is also resistance in filling it out)
 - Orientation from the central level for the integration of HIS necessary
- Even in **vertical programs**, opportunities exist:
 - Management of medicines
 - Permanent education/trainings and trainings in service (e.g., Malaria and AIDS)

Group 6 (questions 5 & 6)

Questions for discussion:

5. *Revitalization of District Health System requires **support to the DPS***
 - *Operating planning and budgeting and investments*
 - *Advocacy with district administration*
 - *Responsiveness to emerging needs*
 - *Promoting equity among districts*
6. *Revitalization of District Health System requires **coherence of external support***
 - *Single results framework?*
 - *National Annual Surveys (rapid KAP planned from WB and WHO)? Shared cost, opportunity to compare provinces*
 - *Province selection by donors?*
 - *What will be standard in the implementation of interventions at district level? What will be variable for learning purposes?*
 - *How to maintain coherence in implementation?*
 - *Support to DPS with limited funding:*
 - *Comprehensive support to fewer provinces?*
 - *Or limited support to more provinces?*
 - *What is the best role for the USG?*

Main points discussed:

- Formal central coordination mechanism for external support needed (long term) – study of experiences of neighboring countries;
- ICC+CCM could be solutions for the short term for coordination;
- Politics of national health plan: the text is ready, only thing missing is approval. Working on establishing a formal forum to discuss and coordinate donor support;
- Improve information systems;
- Map of projects;
- Restrictions in the use of partner funds. Solution: Definition of a basic package, of which the donors would cover certain parts of the package or the entire package;
- Province – could have more than one partner if they were competent.

Group 7 (question 7)

Questions for discussion:

7. *Consensus on the importance of **extending the reach of health services to the community***
 - *Openness to experiment with different models:*
 - *Mobile teams*
 - *CHWs, activists, TBAs*
 - *Medicine posts*
 - *Public and private approaches*
 - *Coordination with traditional authorities*
 - *Interesting pilot experiences: need to evaluate and disseminate results.*

Main points discussed:

- Definition of a political discourse over community services
 - Profile, volunteers, incentives
 - Community agents – could be voluntary at the municipal level, with certain incentives. For example, students could be volunteers and receive a scholarship.
 - Partner - schools and at work sites
 - Use/creation of community pharmacies
 - Mobile teams: are already in the system. CHWs are a continuation of these teams
 - Experiences in Luanda, but there needs to be regulation
 - Coordination with traditional authorities
 - Training and follow up, stores
 - Public and private approach
 - Quick mobilization
 - Participation and continuity
 - Necessity of a policy of communal/community services (beyond health)
 - Coordination with community leaders has to be more participatory and continuous - not only using them, but inviting their participation
 - Counsel on social listening and acceptance: existing mechanism in the districts that should be used in this context. Functioning well in certain areas
 - National counsel on the child: possibility to be an agency that supports the idea of community actors other than in health
 - Auditing committee on maternal and child mortality (wife of administrator) is another option – what happens when the administrator is a woman?
 - Learn from the experiences of other places.

Suggestions from Workshop Participants to USG (anonymous)

- ✓ Engage the community and district forums in the monitoring of local investments in health.
- ✓ Reinforce the formation of an intermediate *quadro* (health worker category).
- ✓ The United States strategy should be in line with integration and revitalization strategies of the national system.
- ✓ Financial support for the health program for maternal child health should be similar to other countries that USAID supports.
- ✓ To include supply of water in the USAID health sector strategy.
- ✓ As part of integration, there should be effective support of HIS.
- ✓ That neglected diseases be an integrated part of the new USAID strategy.
- ✓ Support of pharmaceutical management offers an opportunity for integration and should be explored.
- ✓ To reduce the operational costs with the higher burden of technical assistance.
- ✓ Formation of local implementers through a competitive process to assist expats, and lower proportion of expats to improve the efficiency of resources.

Destaques

- Maior foco político e financeiro na rede primária, já dando alguns resultados
- Constrangimentos sérios na execução – medicamentos essenciais, RH, gestão financeira local, alcance à comunidade
- Oportunidade excepcional de coerência entre os parceiros – como explorar?
- Experiências diversas nas províncias, com parceiros, no sector privado – como explorar?
- Crescimento da sociedade civil – como explorar?

14

1. Revitalização do sistema municipal de saúde exige **fundos**

- No processo orçamental, como influenciar melhor os tetos estabelecidos pelo MINFIN?
- Como garantir fundos mínimos no nível municipal? O RMS, subordinado ao administrador, vai influenciar como?
 - Orçamento fixado pelo MINFIN e MINSA baseado nos dados
 - Advocacia pela DPS
 - Bonus financeiro aos municípios que realizam progresso aos objetivos da Revitalização (progresso verificado por um inquérito independente)
 - Advocacia pela mulher do administrador (governadora de comitê da auditoria de mortes maternas)

16

2. Revitalização do sistema municipal de saúde exige **medicamentos essenciais**

- Como garantir stock contínuo dos medicamentos essenciais?
 - Como garantir a qualidade dos produtos? Precisa de implementar mecanismos novos (do registro até vigilância pós marketing)? Como manter?
 - Como incluir o conceito de qualidade na assistência farmacêutica?

17

3. Revitalização do sistema municipal de saúde exige **recursos humanos**

- Capacitados
 - Como criar e manter um efectivo adequado?
 - Como aproveitar os médicos importados (e forças armadas?) para capacitação dos recursos humanos Angolanos?
- Motivados
 - Reconhecimento público
 - Bonus financeiro

18

4. Revitalização do sistema municipal de saúde, focalizado na mulher e criança, exige a **integração dos serviços**

- Como ligar financiamento vertical com um sistema horizontal de prestação de serviços? Como mostrar resultados aos programas verticais?
- Supervisão integrada?
- SIS harmonizado?
- Como manter um só inventário? Expandir a melhoria das práticas de gestão de inventário, uso racional, e a farmacovigilância para os medicamentos chaves de todos os programas?

19

5. Revitalização do sistema municipal de saúde exige o **apoio provincial (DPS)**

- Planeamento e orçamento operacional e investimentos
- Advocacia com a administração municipal
- Responder às necessidades emergentes
- Promover equidade entre municípios

20

6. Revitalização do sistema municipal de saúde exige **coerência do apoio externo**

- Um único framework de resultados?
- Inquéritos nacionais anuais¹? – custo compartilhado, oportunidade de comparação províncias
- Escolha das províncias pelos doadores?
- Na implementação das intervenções no nível municipal, o que será padronizado? O que será variável para a aprendizagem?
- Como manter coerência na implementação?
- Apoio ao DPS - recursos limitados:
 - Apoio completo a poucas províncias?
 - Ou apoio limitado a mais províncias?
- Qual é o melhor papel do governo dos EU?

1. Annual rapid KAP survey do BM e OMS

21

7. Consenso sobre a importância de **estender o alcance dos serviços ao nível da comunidade**

- Abertura para experimentar modelos diferentes:
 - Equipas móveis
 - Agentes comunitários, activistas, parteiras tradicionais
 - Postos de venda de medicamentos
 - Abordagens públicas e privadas
 - Coordenação com autoridades tradicionais
- Experiências piloto interessantes: necessidade de avaliar e disseminar resultados

22

ANNEX D: SCOPE OF WORK

Health Systems Assessment Update - Angola Health Systems 20/20 Project March 2010

1. Background

In 2005 the Partners for Health Reform*plus* project (PHR*plus*) – the predecessor to the Health Systems 20/20 project (HS 20/20) – conducted a Health System Assessment (HSA) in Angola to inform USAID/Angola's health sector programming. The HSA identified the relative strengths and weaknesses of the country's health system and provided recommendations for improvement.

Since then, numerous USG funded health projects have been implemented in areas such as malaria, HIV/AIDS, TB, family planning, and maternal and child health. Other donors such as UNICEF, the World Health Organization (WHO), the World Bank and the EU have also carried out major activities in Angola with the Ministry of Health (MOH). These efforts have generated rich new sources of information on the state of Angola's health system, and likely produced some results. Currently the MOH is in the process of developing a national health policy and a national health strategic plan, and USG/Angola is consolidating and improving an integrated approach to its health programming in the country. This is an opportune time to update the 2005 assessment and expand the scope of the proposed 2010 assessment to identify the main advancements of USG interventions and inform the MOH and USG/Angola's strategies moving forward.

2. Purpose

The purpose of this assignment is to update the HSA done for Angola in 2005. In particular, the assessment will:

- Review new sources of data that have become available since 2005
- Identify areas of national progress since the 2005 HSA and successful strategies, including a comparison of USAID intervention provinces with non-USAID provinces to measure the impact of USAID's investment
- Identify the continuing challenges to strengthening Angola's Health System, with particular attention to: human resources, health information systems (HIS), commodity security, donor coordination, and translating good planning into action. All are areas of health system weakness that continue to impede the performance of USG programs
- Develop recommendations to help inform the MOH's health strategy
- Help inform USG/Angola's integrated health strategy

HS 20/20 will collaborate closely with the MOH and the WHO to ensure local buy-in and coordination of this HSA with their ongoing efforts. The team will also attempt to engage non-health stakeholders who have a current or potential impact on the health system, such as the Ministry of Finance and Planning, Ministry of Women's Affairs, the Ministry of Youth, the Ministry of Reinsertion, civil society, private business and the CCM of the Global Fund and possibly a representative from Parliament.

3. Methodology

This assessment will use the Health Systems Assessment Approach, a rapid indicator-based process developed by USAID/GH/HIDN that is carried out in two phases: Phase I – Planning and Background Information Review, and Phase II – Field-based Data Collection and Report Preparation. The approach includes six modules: governance/stewardship, financing, service delivery, human resources, pharmaceuticals, and HIS. The assessment will take place on April 4-17, 2010.

PHASE I

Planning and Background Information Review is primarily DC-based and provides a plan for what steps are required during Phase II. Phase I includes: review of background documents, archival materials and other relevant sources, as required, interview(s) with USG agencies/Angola and any US-based key informants, identification of initial key informants, and preparation of a preliminary work plan for Phase II.

Document Review and Client Consultations– *January-March 2010*

Prior to arriving in country and conducting field work, the team will review various documents and reports including but not limited to: the 2005 Angola HSA, health project reports and surveys (not limited to USG), preliminary NHA and MICS results, if available, national health strategy and population reports; Government and other monitoring data; USG strategy documents. The team will consult USG agencies/Angola and USG support staff based in the US such as HIV/AIDS (PEPFAR), malaria (PMI), RH, TB, water and sanitation, democracy and governance. These consultations will refine this scope of work, the assessment methodology, and report outline.

Team Planning Meeting in DC – *February 2010*

A Team Planning Meeting (TPM) will be held, with the HSA team members only, prior to official onset of meetings and work with USG agencies and others. This time will be used to clarify team member roles and responsibilities, deliverables, development of tools and approach to the assessment and redesign and refinement of agenda. In the TPM the team will:

- Share background, experience, and expectations for the assignment
- Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities
- Agree on the objectives and desired outcomes of the assignment
- Develop data collection methods, instruments, tools and guidelines, and methodology
- Develop an assessment timeline and strategy for achieving deliverables

Preparation for Trip – *February-March 2010*

After the TPM, the team will begin to coordinate with USAID/Angola to select and contact the key informants that should be interviewed, determine how to present the HSA concept to obtain their buy-in, draft the field schedule and begin setting up appointments.

PHASE 2

This phase includes: in-country work including Team Planning Meeting with USAID, key informant interviews, site visits, continued information/data collection to enrich the areas of inquiry identified during Phase I, debriefings with USG agencies, a stakeholder workshop, and submission of a draft report. After the country visit, the final report will be revised based on feedback from USG agencies and other stakeholders and undergo editing/formatting before final submission and release of the final report.

Arrival – Team Planning Meeting with USG agencies/Angola – April 2010

Upon arrival the team will meet with USG agencies/Angola to: review the priorities for the assessment and assessment methodology; finalize the key research questions and examine the field schedule (in which appointments will USG agencies/Angola staff participate? schedule check-in meetings or calls); review logistics, protocol for communications with USAID/Angola, other donors and government contacts, and for interviews during the field visits; and plan for stakeholder workshop.

Field Visits/Key Informant Interviews – April 2010

Site visits will be critical to understand health system performance at the service delivery level. Interviews with the key informants will include but not be limited to MOH officials, USG agencies, Implementing Partners, other donors, private and commercial partners, civil society organizations.

USG agencies/Angola Debrief – April 2010

Prior to the stakeholder workshop, the team will debrief USG agencies/Angola and discuss preliminary findings and recommendations, outstanding questions, and review draft presentation (ppt) for the stakeholder workshop.

Stakeholder Workshop – April 2010

A ½ day workshop will be held with USG agencies/Angola and other key stakeholders after the site visit work is completed and prior to the departure of the team from the country. The participants will include USG agencies partners and stakeholders (as appropriate). The Mission might consider co-hosting with the MOH and/or WHO. In this meeting the assessment team will present findings for comment and validation, and facilitate group discussion of recommendations for national health system strengthening, but no recommendations for future USG agencies programming. USAID and the MOH will send out the invitations and HS 20/20 will cover expenses for this meeting, including meeting space.

Preliminary Draft Report – April 2010

The full report timeline will take a total of 4-5 weeks. Based on all the information collected in country, including the USG/Angola debrief and the Stakeholder Workshop, the team will submit a preliminary draft report including findings and recommendations upon completion of the field work and before the team departs Angola (April 17). The draft report will incorporate comments and feedback from the debriefings. This report should not exceed 50 pages in length (not including appendices, lists of contacts, etc.). This draft will include findings and recommendations for Mission review. USG agencies/Angola will have two to three weeks to provide comments and suggestions to the assessment team, including comments from the MOH, which shall be addressed in the final report.

Final Report – May-June 2010

The team will submit a final report no later than one week after USG agencies/Angola provide written comments on the team preliminary draft report. This report should not exceed 50 pages in length (not including appendices, lists of contacts, etc.). The format will include executive summary, table of contents, findings and recommendations. Once the final report is approved, it will take an additional week to edit and format it. The report will be submitted in Portuguese/English, electronically for dissemination among implementing partners and stakeholders.

4. Team Composition

The assessment team will consist of one Team Leader, one public health specialist, one USAID staff member (participant of the 2005 assessment), one international consultant, one local specialist, one staff from the MOH, and a Research Assistant. Collectively the team members should have strong backgrounds to comprehensively cover all six modules: governance/stewardship, financing, service delivery, human resources, pharmaceuticals, and HIS.

Team Leader – Catherine Connor, HS 20/20

The Team Leader will be responsible for managing the team in conducting the assessment and in preparing and finalizing all deliverables. This individual will be responsible for achieving assignment objectives as well as briefings and presentations, and will be the key liaison with USAID/Angola. The Team Leader is fluent in Portuguese and has more than 10 years of experience leading assessment teams, including the 2005 Angola HSA, and preparing high quality project documents. The Team Leader will:

- Finalize and negotiate the HSA work plan with client
- Establish assignment roles, responsibilities, and tasks for each team member
- Ensure that the logistics arrangements in the field are complete
- Facilitate the Team Planning Meeting or work with a facilitator to set the agenda and other elements of the TPM
- Take the lead on preparing, coordinating team member input, submitting, revising and finalizing the assignment report
- Take the lead with producing one or two modules of the assessment
- Manage the process of report writing
- Manage team coordination meetings in the field
- Coordinate the workflow and tasks and ensure that team members are working to schedule
- Ensure that team field logistics are arranged (e.g., administrative/clerical support is engaged, ensuring that payment is made for services, car/driver hire or other travel and transport is arranged, etc.) in coordination with team

Public Health Specialist – Denise Averbug, HS 20/20

The Public Health Specialist will support the Team Leader in all of the above-mentioned tasks and will carry out one or two modules of the assessment. The Public Health Specialist is a native Portuguese speaker and has five years of experience in public health programming, particularly reproductive health, HIV/AIDS and the private sector.

International consultant – Maria Miralles, International Relief and Development

This consultant is an expert of Pharmaceutical Systems and will be responsible for the pharmaceuticals module.

Research Assistant – Erica James, HS 20/20

Because of the substantial requirements for assembly of materials required for the assessment as well as logistical arrangements, the team includes a Research Assistant for approximately 10 days over the assignment period. She will be responsible for the following tasks:

- Identifying, collecting and cataloging for easy retrieval by the team members relevant documents, surveys and other related background and historical reference materials as requested by the team
- Assisting with identification of key informants
- Providing scheduling support as required
- Compiling, managing and overseeing information collected through Key Informant interviews, Focus Groups, Site Visits and other background research
- Producing a final bibliography of all sources utilized in the assessment
- Providing additional research support to the Team Leader, as required

5. Logistics

USAID/Angola will assist with arranging:

- Contact and meetings with key informants in-country

- Mid-assessment Meeting: mid-way through the team's field work the team and USG/Angola will discuss the findings to date and troubleshoot possible obstacles towards completing the assessment as planned
- USG Debrief Meeting to be held at the conclusion of the field work but prior to the Stakeholder Workshop
- Invitations for the Stakeholder Workshop to be held at the conclusion of the field work and following the USG debrief. HS 20/20 will cover expenses for this meeting, including venue.

USAID/Angola will provide overall direction to the assessment team, identify key documents and assist in facilitating a work plan. USAID/Angola will assist in arranging and/or participate in meetings with key stakeholders as identified by USG prior to the initiation of fieldwork. The Mission will be responsible for ensuring that the consultants have all of the relevant documents for review, provide technical guidance to the team on the plans, outputs and feedback, and commit time, effort and necessary support to the consultants to enable them to execute their task. Review draft report and provide feedback, and sign off on final report.

USAID/Angola personnel shall be available to the team for consultations regarding sources and technical issues, before and during the assessment process

The HS 20/20 assessment team is responsible for arranging other meetings as identified during the course of this assessment and advising USAID/Angola prior to each of those meetings. The assessment team is also responsible for arranging vehicle rental and drivers as needed for site visits.

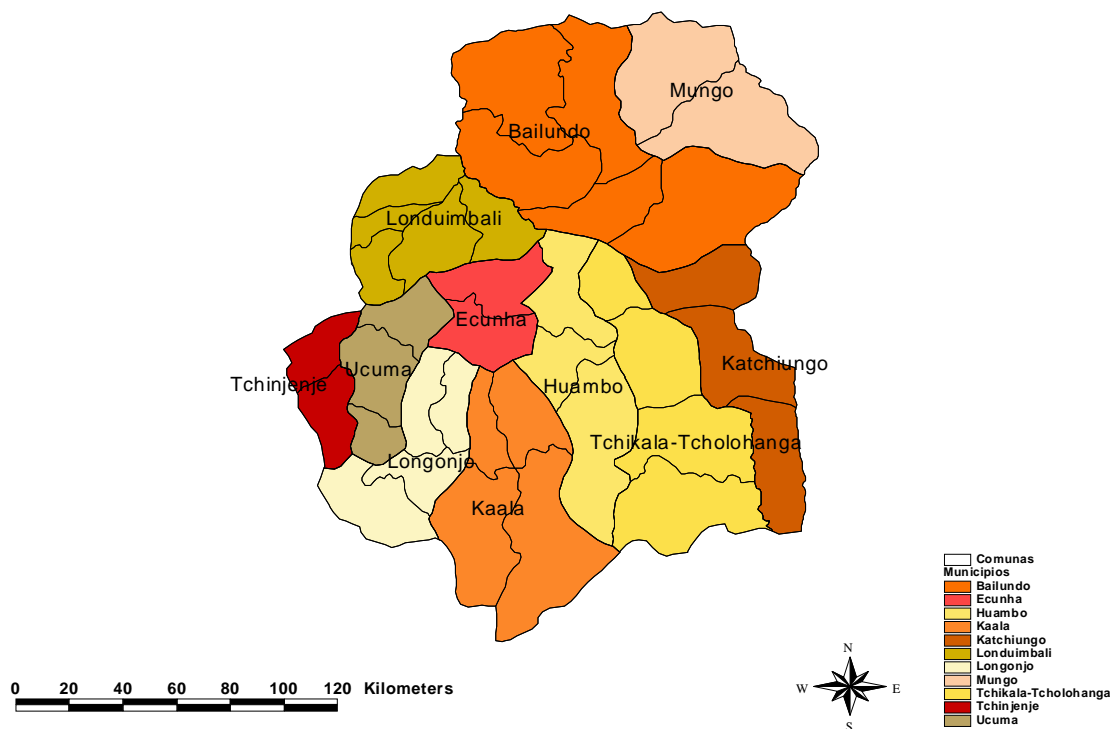
6. Deliverables and Products

- *Work plan*
- *USG Debrief*
- *Stakeholder Workshop*
- *Preliminary Draft Report*
- *Final Report*

Health Systems 20/20 will be responsible for editing and formatting the final report, which takes up to one week after the final unedited content is approved by USG agencies.

ANNEX E: FIELD VISIT TO HUAMBO PROVINCE (11–14 APRIL, 2010)

Denise Averbug, Abt Associates
Gisele Guimarães, USAID/Angola
Maria Miralles, IRD



April 12

Huambo Provincial Health Authorities

- Direcção Provincial de Saúde (Dr. Findes, Director)
- Programa de Medicamentos, (Cesário & Noemia)
- Provincial medical store and annex

Huambo District

- Health Center, São João (Justina Eculica, Director; Nurse Janine)

Caála District

- Caála District Hospital (Dr. Fernando Vicente)

Huambo Provincial Programs Heads

- Programa de Saúde Reprodutiva (Rosalina)
- Núcleo de Formação Permanente (Augusta)
- Programa de VIH/SIDA (Euclides)

USAID/Serviços Essenciais de Saúde (SES) Program Office

- ES Huambo team, Margarita (Chief of Party) and Jhonny

April 13**Bailundo District**

- Bailundo District Hospital (Dr. Daniel)
- Bailundo District RMS Head representative (RMS Head not present)
- Bailundo District Director of Public Health (Benedito Blanco)
- Bailundo District Health Supervisor (SES)
- Provincial Medicines Program
- Private Drug Shop
- Mentor Initiative Program Office

April 14**Return to Luanda**

- Health Post of Luvili, Alto Hama, Huambo Province

ANNEX F: CONTACT LIST

Organization	Name	Title	E-mail	Telephone
USG Washington				
USAID	Erin Balch	Public Health Analyst	ebalch@usaid.gov	202-712-5082
USAID	Bob Emrey	Public Health Advisor	bemrey@usaid.gov	202-712-4583
USAID	Mary Harvey	Public Health Advisor	mharvey@usaid.gov	202-712-5483
USAID	Deborah Kaliei	Presidential Management Fellow	dkaliei@usaid.gov	202-712-0254
USAID	Liz Kibour		ekibour@usaid.gov	202-712-4808
USAID	Lisa Maniscalco	Global Health Fellow	lmaniscalco@usaid.gov	202-712-1018
USAID	Deborah Mendelson		dmendelson@usaid.gov	202-712-0302
USAID	Roy Miller	Senior Health Advisor	rmiller@usaid.gov	202-712-1483
USAID	Edwin Connerley	Bureau of Democracy and Governance	econnerley@usaid.gov	202-712-4857
USAID	Mary Ann Abeyta-Behnke	Sr. RH/FP and HIV/AIDS Integration Advisor	mabeyta-behnke@usaid.gov	202-712-5849
USAID	Trent Ruebush	GH/HIDN/ID PMI	truebush@usaid.gov	202-712-5734
USG Angola				
USAID/Angola	Bart Bruins	Health Team Leader	bbruins@usaid.gov	+244 222 641 119
USAID/Angola	Domingas Canhanga		dcanhanga@usaid.gov	+244-222-641 114
USAID/Angola	Giselle Guimaraes		gguimaraes@usaid.gov	
USAID/Angola	Ana Johansen	HIV/AIDS Advisor	ajohansen@usaid.gov	
USAID/Angola	Valentina Mbithe		vmbithe@usaid.gov	
USAID/Angola	Randall G. Peterson	Mission Director	rpeterson@usaid.gov	+244 222 641 000/1114
USAID/Angola	Francisco Saute	Advisor	fsaute@usaid.gov	+244 250 2987
CDC/Angola	Jules Mihigo	Advisor	ftb8@cdc.gov	+244 926 07 08 38
Government of Angola				
DNRH	Oscar Isalino		oscarisalino@hotmail.com	+244 923 519 460
DNSP/SR	Maria Gabriella ??			+244 951 74180
DNSP	Helga Freitas			+244 923 400 545
DNSP	Sr. dos Santos			+244 912 226 322
Department of Public Health, Maianga	Isilda Neves	Chief, Department of Public Health	isildaneves@hotmail.com	+244 926 64 07 17
Ministry of Health	José Van Dúnem	Minister of Health		
Ministry of Health	Evelize Joaquina da Cruz Festes	Vice Minister of Health		

Organization	Name	Title	E-mail	Telephone
Ministry of Health	Dra. Adelaide de Carvalho	National Director of Public Health	fafernandes@snet.co.ao	+244 222 330 435
Ministry of Health	Maria de Fatima Hambundo Saiundo	Coordinator, Program Management Unit GFATM	nsaiunda@yahoo.com.br	+244 222 336 056
Ministry of Health	Jorge Humberto Romero	Consultant, Office of Studies, Planning & Statistics	jromerososa@gmail.com	+244 222 336 056
Ministry of Health	Boaventura Moura	National Director of Medicines and Equipments		+244 926 731 477
Ministry of Health	Dr. Manaças	Director, Sessential Drugs Program		
Ministry of Health	Constancio João	Chief Logistician, National Essential Drugs Program		
Ministry of Health	Daniel Antonio	Director GEPE/MINSA		+244 912 508 836
Ministry of Health	Sr. Terreiva	Department Head		+244 923 402 780
Ministry of Health/INLS	Lucia M. Furtado	Deputy Director, INLS		+244 233 03515
National Institute for Fight Against AIDS (INLS)	Dra. Ducelina Serrano	Director		+244 923 432 820
Ministry of Health, Provincial Health Directorate of Huambo	Dr. Finde	Director		
Ministry of Health, Provincial Health Directorate of Huambo	Cesario Noemia	Head, Medicines and Equipment Department		
Ministry of Health, Provincial Health Directorate of Huambo, Caala Hospital	Dr. Fernando Vicente	Director		
Ministry of Health, Provincial Health Directorate of Huambo, Bailundo Hospital	Dr. Benedito Blanco	Director		
Country Coordinating Mechanism for GFATM	Dr. Evelisa Frestas			
UN Agencies	Name	Title	Email	Telephone
UNAIDS/Angola	Tamsir O. Sall	Country Coordinator	salt@unaids.org	+244 222 33 1181
UNAIDS/Angola	Claudia Velasquez	Advisor	velasquezcl@unaids.org	+244 928 647 404
UNFPA	Luisa dos Santos	Consultant	dosantos@unfpa.org	+244 934 441 5651
UNICEF	Dr. Koenraad Vanormelingen	UNICEF Representative, Angola	kvanormelingen@unicef.org	+244 222 336 044
UNICEF	Brandao Co	Chief, Accelerated Child Survival and Development	bco@unicef.org	+244 222 331 420

Organization	Name	Title	E-mail	Telephone
WHO/Angola	Felix Balbina	DPC Unit	felixb@ao.afro.who.int	+244 924 329 606
WHO/Angola	Dr. Gregoire Batakao		batakaog@ao.afro.who.int	+244 222 322 398
WHO/Angola	Dr. Albert Minyangadou	Administrator	minyangadoua@ao.afro.who.int	+244 222 322 398
WHO/Angola	Dr. Munzala Ngola	WHO, Angola	ngolam@ao.afro.who.int	+244 222 332 398
WHO/Angola	Maria Jose Costa	WHO, Angola		+244 935 594 928
WHO/Angola	Dr. Seydou Coulibaly	WHO, Angola	coulibalys@ao.afro.who.int	+244 222 332 398
WHO/Geneva	Norbert Dreesch	Technical Officer, Health Systems and Services	dreeschn@who.int	+41 22 791 44 49
WHO/Geneva	Dr. Regina Ungerer	ePORTUGUESE Coordinator	ungererr@who.int	+41 79 500 65 63
WHO/HMN – Geneva	Habtmu Argaw Addo	Tech Officer, HMN	addoh@who.int	+41 22 791 13 78
WHO/HMN - Geneva	John Robert Cutler	Chief of Country Programmes	cutlerj@who.int	+41 22 791 3726
Other Contacts				
Consaúde –LDA	Paula Figueiredo	Sócia Gerente	consaudealternative@gmail.com	+244 33 74 72
Chemonics/ Washington, DC	Oscar Cordon	Director, Africa	ocordon@chemonics.com	202-775-6977
Chemonics/Angola	Margarita Gurdian	SES Chief of Party	mgurdian@sesangola.net	+244 222 331 244
Chemonics/Angola	Erica Hill	Operations Manager SES Project	ehill@sesangola.net	+244 926 079 755
Chemonics/Angola	Amaisio Melo	Coordinator SES Project		+244 923 475 321
Development Workshop	Alan Cain	Director	Allan.devworks@angonet.org	+244 222 449 494
HAMSET/ World Bank	Dra. Ana Leitao		hamsetaleitao@gmail.com	+244 9234 01243
Pathfinder/Angola	Hirondina Cucubica	Representative	Hcucubica@gmail.com	+244 9250 74840
Pathfinder/ Washington, DC	Maribel Diaz	Sr. Program Officer ESD Project	mdiaz@esdproj.org	202- 775-1977
PSI/Angola	Luis Fernando Martinez	Director	luisfer@psiangola.org	+244 9263 96630
European Union	Raul Feio	Perito de Saúde	Raul.feio@ec.cuvofc.eu	+244 2 39 30 38
MSH/Strengthening Pharmaceutical Systems	Dr. Wonder Goredema	Program Manager	wgoerdema@msh.org	
JSI/DELIVER	Christopher Warren	Program Manager	cwarren@jsi.com	

ANNEX G: DOCUMENTS CONSULTED

- Brinkerhoff, DW and Bossert, T. 2008. *Health Governance: Concepts, Experience, and Programming Options*. Health Systems 20/20 Policy Brief. Online at www.hs2020.org.
- Cain, Allan and Mulenga, Martin. 2009. *Water Service Provision for the Peri-Urban Poor in Post-Conflict Angola*. Human Settlements Working Paper Series No. 6. International Institute for Environment and Development (IIED). August. Online at: <http://www.iied.org/pubs/pdfs/10577IIED.pdf>
- CARE International, Angola. 2006. *Strengthening Community Resilience and Responses to Hiv/Aids Through Livelihoods in Bié Province*. Monitoring and Lesson Learning Mission Report.
- Chowdhury, Taskeen. 2009. Pay for Performance of Community Health Workers (CHWs): BRAC's Experience. Workshop. Cebu, Philippines. Online at: <http://www.healthsystems2020.org/content/resource/detail/2190>
- "CQH em Angola." *Compromisso com a Qualidade Hospitalar*. Online at: <http://www.cqh.org.br/?q=node/696>
- Connor, Catherine, Yogesh Rajkotia, Ya-Shin Lin, and Paula Figueiredo. 2005. *Angola Health System Assessment*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc. (October.). Online at: <http://www.healthsystems2020.org/content/resource/detail/1672/>
- Consultoria de Serviços e Pesquisas (COSEP) Lda., Consultoria de Gestão e Administração em Saúde (Consaúde) Lda. [Angola], and Macro International Inc. 2007. *Angola Malaria Indicator Survey 2006-07*. Calverton, Maryland.
- Darmstadt, Gary et al. 2005. "Evidence-Based, Cost-Effective Interventions: How Many Newborn Babies Can We Save?" *The Lancet*. Volume 365, Issue 9463. (March.)
- Development Workshop. 2007. *Perfil do Município do Andulo: Província do Bié*. (July.).
- Development Workshop 2007. *Perfil do Município do Cuito Cuanavale: Província do Kuando Kubango*. (July.)
- Development Workshop 2007. *Perfil do Município de Cabinda: Província de Cabinda*. (July.)
- Development Workshop 2007. *Perfil do Município da Chicala Choluanga: Província do Huambo*. (July.)
- Estatuto da Ordem dos Médicos de Angola. (Charter of the Professional Association of Medical Doctors in Angola). Online at: http://www.ordemmedicosangola.com/cariboost_files/Estatutos_200MA.pdf

- Gamal Khalafalla Mohamed Ali. 2009. "How to Establish a Successful Revolving Drug Fund: The Experience of Khartoum State in the Sudan." *Bulletin of the World Health Organization* 87: 139-142. Online at: <http://www.who.int/bulletin/volumes/87/2/07-048561/en/index.html>
- Gaudiano, MC et al. 2007. "Medicines Informal Market in Congo, Burundi and Angola: Counterfeit and Substandard Anti-malarials." *Malaria Journal* 6:22.
- GAVI Alliance. 2007. *Annual Progress Report: Angola*.
- GAVI Alliance. 2008. *Angola Country Fact Sheet*. Online at: <http://www.gavialliance.org>
- Governo da Provincia de Luanda. Direccao Provincial de Saude. 2010. *Plano de Actividades Trimestral Janeiro a Marzo*.
- Health Metrics Network. 2010. *Resultados do Seminario de Março 2010 da Avaliação Nacional do Sistema de Informação Sanitaria (SIS)*. (Março.)
- International Monetary Fund. 2007. *Angola: Selected Issues and Statistical Appendix*. Country Report No. 07/355. (October.)
- International Monetary Fund. 2009. *Angola: Request for Stand-By-Arrangement*. Country Report No. 09/320. (November.)
- Islam, M., ed. 2007. *Health Systems Assessment Approach: A How-To Manual*. Submitted to the U.S. Agency for International Development in collaboration with Health Systems 20/20, Partners for Health Reformplus, Quality Assurance Project, and Rational Pharmaceutical Management Plus. Arlington, VA: Management Sciences for Health. Online at: <http://www.healthsystems2020.org/content/resource/detail/528/>
- Kumar, Vishwajeet et al. 2008. "Effect of Community-Based Behavior Change Management on Neonatal Mortality in Shivgarh, Uttar Pradesh, India: A Cluster-Randomised Controlled Trial." *The Lancet*. Volume 372. Issue 9644. (September.)
- Lopes, Ana and Paula Fialho. "Poverty Reduction Strategies in Conflict-affected Countries: Constraints and Opportunities." Draft.
- Management Sciences for Health. 1997. *Managing Drug Supply: Second Edition, Revised and Expanded*. Section B Financing and Sustainability. Pages 605-709. West Hartford, Connecticut: Kumarian Press.
- Ministério da Saúde. Gabinete de Estudos, Planeamento e Estatística. 2010. *Relatorio de Avaliação Nacionnal do Sistema de Informacao Sanitaria (SIS)*. Versão provisória 2. (Março.)
- Ministério da Saúde. 2007. *Avaliação do Sector Farmacêutico de Angola*. (Agosto.)
- Ministério da Saúde. Gabinete de Estudos, Planeamento e Estatística. Angola. *Despesa Pública no Sector da Saúde. 2000-2006*. Ed Princípia. 2007
- Ministério da Saúde. Gabinete de Estudos, Planeamento e Estatística. 2007. *Mapa Sanitário da Província de Luanda*.

- Ministério da Saúde. Gabinete de Estudos, Planeamento e Estatística. 2007. Mapa Sanitário da Província de Benguela.
- Ministério da Saúde. Gabinete de Estudos, Planeamento e Estatística. 2007. Mapa Sanitário da Província do Huambo.
- Ministério da Saúde. Gabinete de Estudos, Planeamento e Estatística. 2007. Mapa Sanitário da Província de Huíla.
- Ministério da Saúde. Gabinete de Estudos, Planeamento e Estatística. 2007. Mapa Sanitário da Província do Bié.
- Ministério da Saúde. 2009. Revitalização do Sistema Nacional de Saúde a Nível Municipal. 3º Rascunho. (Setembro.)
- Ministério da Saúde. 2008. O Sistema Local de Saúde em Angola. Conceitos de Modelo para a Planificação District e Provincial.
- Ministério da Saúde. Gabinete de Estudos, Planeamento e Estatística. 2008. O Sistema Local de Saúde em Angola. Conceitos e Modelo para a Planificação Municipal e Provincial. Documento de Trabalho. (Maio.)
- Ministério da Saúde. Organigrama. Online at:
http://www.minsa.gov.ao/Institucional/MINSA/orga_minsau.html
- Ministry of Finance of the Republic of Angola. 2009. Resumo da Despesas por Local- OGE 2009. Online at: <http://www.minfin.gv.ao/docs/dspSintese2009-4.htm>
- Ministry of Planning of the Republic of Angola. 2003. *Estratégia de Combate à Pobreza Reinserção Social, Reabilitação e Reconstrução e Estabilização Económica.*
- National Cooperative Business Association. 2003. "Angola Farmers Access Credit." *Cooperative Business Journal*. (August/September.)
- National Cooperative Business Association. 2004. "Bank Loans Help Angolan Farmers Boost Production, Meet Demand." *Cooperative Business Journal* (October.)
- National Cooperative Business Association. 2002. "CLUSA Close-up: Angola's Farmer-Owned Businesses Rack Up First Success." *Cooperative Business Journal* (December.)
- Organisation for Economic Cooperation and Development. 2006. *Perspectivas Económicas na Africa 2004/2005: Angola.*
- Partners in Health. PIH Model Online. Community Health Workers: Catalysts to Improving Health Care. Online at: http://model.pih.org/community_health_workers
- Pielemeier, John. 2007. *Lessons from the First Generation of Integrated Population, Health and Environment Projects.* A Woodrow Wilson International Center for Scholars Focus Publication. January. Online at: http://wilsoncenter.org/topics/pubs/Focus_12.pdf
- PEPFAR. 2010. *Partnership Framework Implementation Plan. Angola.* (Draft)

- President's Malaria Initiative. 2010. *Malaria Operational Plan- Year Five Plan (FY2010)*.Draft.
- Principia 2007 (see Vinyals, Lluís Torres 2007 below)
- Programa de Apoio ao Sector de Saúde (PASS)*. (Program to Support the Health Sector - EU Project). 2008. Data from the Health Maps of Five Provinces.
- Republic of Angola. 2003. *Diário da República (Government Gazette)*. Decreto 54/03. Regulamento Geral das Unidades Sanitárias do Serviço Nacional de Saúde.
- Republic of Angola. 2007. *Diário da República (Government Gazette)*. Decreto-Lei 2/07. Princípios e Normas de Organização e Funcionamento Dos Órgãos da Administração Local do Estado.
- Republic of Angola. 2008. *Protocol for National Health Accounts (NHAs) in Angola*. Republic of Angola Ministry of Health, World Health Organization, French Embassy in Angola. (July.)
- Republic of Angola. 2003. *Qualitative Factors Determining Poor Utilization of Family Planning Services in Angola: Results of the Strategic Mapping Exercise*. Angola Ministry of Health, National Office of Public Health, Advance Africa, USAID/Angola.
- Republic of Angola and European Community. 2008. *Country Strategy Paper and National Indicative Programme, 2008-2013*. Luanda, Angola. (November.)
- Republic of Angola. 2010. *Orçamento Geral do Estado: Exercício Económico de 2010*.
- Republic of Angola. 2010. *Relatorio de Fundamentação 2010*.
- República de Angola, Ministério da Saúde, Gabinete de Estudos, Planeamento e Estatística. 2007. *Mapa Sanitário: CARACTERIZAÇÃO DO SISTEMA DE PRESTAÇÃO DE SERVIÇOS DE SAÚDE (Provincia do Huambo)*. Huambo, Angola.
- República de Angola, Ministério da Saúde, Gabinete de Estudos, Planeamento e Estatística. 2007. *Mapa Sanitário: CARACTERIZAÇÃO DO SISTEMA DE PRESTAÇÃO DE SERVIÇOS DE SAÚDE (Provincia de Luanda)*. Luanda, Angola.
- Rispel L., and Setswe G. Stewardship. 2007. "Protecting the Public's Health." *South African Health Review*. Durban: Health Systems Trust.
- Salgado, Rene and Mike Frost. 2008. *Task Order 3 (Malaria): FY2008 Annual Report*. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 3.
- Shaxon, Nicholas, João Neves, and Fernando Pacheco. 2008. *Drivers of Change, Angola*. Final Report. Department for International Development.
- Thaxton, Melissa. 2009. Integrating Population, Health and Environment in Rwanda. Population Reference Bureau Policy Brief. (February.) <http://www.prb.org/pdf09/phe-rwanda.pdf>
- United Nations and Government of the Republic of Angola. *United Nations Development Assistance Framework/Angola 2009-2013*. (May.)
- United Nations Development Program (UNDP). *Strategic Framework for UNDP Operations in Angola (2009-2013)*. Available online at: <http://www.ao.undp.org>.

- United Nations Development Program (UNDP), Department for International Development (DFID), and Spanish Cooperation. Decentralization and Local Governance Project. *Project Annual Report 2009 (Phase II)*.
- United Nations Development Program (UNDP) and Republic of Angola Ministry of Planning. *Country Programme Action Plan 2009-2013*.
- UNICEF. 2009. *Country Profile: Maternal, Newborn & Child Survival*. Online at: <http://www.unicef.org>
- UNICEF, Division of Policy and Practice, Statistics and Monitoring Section. 2008. "Monitoring the Situation of Women and Children." May. Online at: www.childinfo.org
- UNICEF, UNAIDS, and WHO. 2009. *Children and AIDS: Country Fact Sheets 2009*. (December.)
- UNICEF/National Institute of Statistics. 2003. Multiple Indicator Cluster Survey. *Assessing the Situation of Angolan Children and Women at the Beginning of the Millennium*. Luanda, Angola. (May.)
- UNICEF. *Revised Country Programme Document: Angola (2009-2013)*. (February.)
- UNICEF, Angolan Ministry of Health and Directorate of Public Health. 2007. *Relatório do Inquérito sobre a Nutrição em Angola 2007*. (National Situational Analysis Report on Nutrition).
- United States Agency for International Development (USAID). 2009. *Country Health Statistical Report, Angola, 2009*.
- Vinyals, Lluís Torres 2007. *Angola: Despesa Pública no Sector da Saúde 2000-2006*. Princípiá Editora, Lda. March 2007.
- World Health Organization *Bulletin*. 2010. Volume 88, Number 5. 321-400. May. Online at: <http://www.who.int/bulletin/volumes/88/5/en/index.html>
- World Health Organization (WHO). 2009. "Evaluation on the use and sources of human resources for health data in Angola." Draft. (October.)
- World Health Organization (WHO). 2006. *Country Health System Fact Sheet 2006*. Online at: <http://www.who.int/whosis/en/>
- World Health Organization (WHO). 2000. World Health Report.
- World Health Report (WHO). 2006. World Health Report.
- World Health Organization Regional Office for Africa. 2009. *Estratégia de Cooperação da Organização Mundial da Saúde com os Países, 2009-2013 Angola*.
- World Health Organization Regional Office for Africa. 2003. *WHO Country Cooperation Strategy: Angola 2002-2005*.
- World Bank. 2004. *Country Financing Parameters: Angola*. (October.)
- World Bank. 2009. *Information and Communications Technology Factsheet: Angola*.
- World Bank. 2009. Development Economics LDB Database. *Angola at a glance*.

World Bank. 2009. Angola HIV/AIDS, Malaria & Tuberculosis Project (HAMSET) Procurement Plan. (November.)

World Bank. 2009. Angola Municipal Health Service Strengthening Project. *Environmental and Social Screening and Assessment Framework*. Report No. E2146V3.

World Bank. 2009. *Argentina: Plan Nacer*. Results-Based Financing at the World Bank. Online at: http://www.rbhealth.org/rbhealth/system/files/RBF_Country_ARGENTINA_final.pdf

World Bank. 2010. “Programa de Pequenos Fundos, Fundo de Desenvolvimento da Sociedade Civil.” *Informações Sobre o Programa (Para Organizações da Sociedade Civil)*.