Partners for Health Reform*plus*

Angola Health System Assessment

September 2005

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- *Delivery of quality services by health workers.*
- *Availability and appropriate use of health commodities.*

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Abstract

At the request of the U.S. Agency for International Development (USAID)/Angola, a team performed an assessment of the Angolan health system in August 2005. The purpose of the health system assessment is to inform the Mission's development of a new health program for 2006–2011. To conduct the assessment, the team tested a new health systems assessment approach developed as part of the global Mainstreaming Health Systems Strengthening Initiative of USAID's Office of Health, Infectious Disease and Nutrition. The team found several weaknesses including a lack of human and institutional capacity and supervision; and insufficient 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 dedication of public sector health staff at multiple levels, implementation of some quality guidelines (IMCI and maternal health); and public–private partnerships in health.

Angola currently presents some windows of opportunity because it is in a post-war transition period; Angolans are open to change and anxious for improvement; the young population (60 percent of Angolans are under the age of 18) has a shorter memory of the war; elections promised for 2006; Angola's long-term economic outlook is very positive; and other donor investments in health system strengthening are in progress or planned (European Union, U.N. Development Programme/Global Fund, World Bank) with convergence of goals and strategies. On the other hand, Angola faces certain threats, including the risk that elections in 2006 could generate a flurry of facility construction that is not part of a rational plan or part of the health budget for recurrent costs. The country's cost structure is exceptionally high.

The team's recommendations for health system strengthening activities are consistent with the Mission's proposed strategy statement, Africa Bureau's new Strategic Framework (in which Angola is classified as a fragile state), and other donor initiatives. The team's findings and recommendations were presented at a stakeholder workshop where participants worked in small groups to review and provide feedback.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BP	British Petroleum
CARE	CARE International
CDC	Center for Disease Control and Prevention (U.S.)
CONGA	Network of International NGOs in Angola
CORE	Child Survival Collaboration and Resource Group
CPI	Corruption Perception Index
DFID	Department for International Development/UK
DPS	Provincial Health Directorate
DHS	Demography Health Survey
EPI	Expanded Programme on Immunization
EU	European Union
FONGA	Network of National NGOs in Angola
GDP	Gross Domestic Product
GEPE	Cabinet of Studies, Planning and Statistics
HDR	Human Development Report
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HRD	Human Resources Directorate
ICC	Inter-agency Coordinating Committee
IDA	International Development Association
IMCI	Integrated Management of Child Illness
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INE	*Instituto Nacional de Estatistica*
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey

MINARS	Ministry of Assistance and Social Reintegration
MMR	Maternal Mortality Ratio
MOF	Ministry of Finance
MOH	*Ministério da Saúde* (Ministry of Health)
MOP	Ministry of Planning
MSH	Management Science for Health
NDPH	National Directorate of Public Health
NEDP	National Essential Drug Program
NGO	Nongovernmental organization
PHC	Primary Health Care
PHR*plus*	Partners for Health Reform*plus* Project
QAP	Quality Assurance Project
RPMplus	Rational Pharmaceuticals Management Plus
SSA	Sub-Saharan Africa
SO	Strategic Objective
SWOT	Strengths, Weaknesses, Opportunities, Threats
TB	Tuberculosis
TCU	Transitional Coordination Unit
UNDP	U.N. Development Program
UNFPA	U.N. Population Fund
UNICEF	U.N. Children's Fund
UNITA	National Union for the Total Independence of Angola
USAID	U.S. Agency for International Development
UTCAH	Technical Unit for Assistance Coordination
WDI	World Development Indicators
WDR	World Development Report
WHO	World Health Organization
WHOSIS	World Health Organization Statistical Information System

Acknowledgments

This health system assessment for Angola was funded by the United States Agency for International Development (USAID) Mission in Angola. The Partners for Health Reform*plus* Project conducted the assessment in collaboration with the Quality Assurance Project, USAID's Office of Health, Infectious Disease and Nutrition, and Consaúde, a local consulting firm. The assessment team is indebted to the dozens of stakeholders in Angola who were so generous with their time and insights. The assessment team is very grateful for the extensive support of USAID/Angola, especially Diana Swain, Mission Director, who articulated an integrated systems strategy for USAID assistance in Angola; and the significant involvement of Cathy Bowes and Judy Wiegert who participated in the assessment, arranged contacts, field visits, two focus groups, the stakeholder workshop and did a detailed review of this report. The team also thanks Charlotte Leighton and Mursaleena Islam for reviewing the draft report, and Linda Moll and Maria Claudia De Valdenenbro for final editing and formatting.

1. Background

At the request of the U.S. Agency for International Development (USAID)/Angola, a three-person team performed an assessment of the Angolan health system from August 6–19, 2005. The purpose of the assessment was to inform the Mission's development of a new health program for 2006–2011. The team comprised team leader Catherine Connor, of the Partners for Health Reform*plus* (PHR*plus*); Quality Assurance Project technical specialist Ya-Shin Lin; and USAID health systems and financing specialist Yogesh Rajkotia. Dr. Paula Figueiredo assisted the team extensively with interviews, data collection, and analysis/interpretation.

In addition to assessing the country's health system for USAID/Angola, the team tested a new Health Systems Assessment Approach that was developed as part of USAID's Office of Health, Infectious Diseases and Nutrition's (HIDN's) global Mainstreaming Health Systems Strengthening Initiative. The purpose of the mainstreaming initiative, launched in September 2004, is to find new cost-effective ways to put the combined knowledge, expertise, and tools of USAID Global Health Bureau's health system strengthening projects at the service of USAID's large bilateral health service delivery projects in order to improve these projects' capacity to achieve USAID health impact objectives.

PHR*plus* is developing the assessment approach in collaboration with Rational Pharmaceuticals Management Plus (RPMplus), Quality Assurance Project (QAP), and other Health Systems Division projects. The Health Systems Assessment Approach is meant to:

- Allow Population, Health and Nutrition (PHN) officers to conduct an assessment of a country's health system, possibly during early phases of program development (with the assistance of experts/consultants if necessary). This will include diagnosing the relative strengths and weaknesses of the health system
- Help improve the capacity of bilateral projects to achieve USAID's health impact objectives through increased use of health systems interventions
- Help health systems officials at USAID to conceptualize key issues, increase the use of health systems interventions in technical program interventions, and improve the role of the Health Systems Division.

The first phase of the work (January–June 2005) entailed conceptualizing, designing, and drafting the approach. The second phase consists of pilot testing it in at least two countries and revisions. Angola is the first country in which the tool is being pilot tested.

Preceding this assessment, in February 2005, a team from USAID/Washington reviewed the Mission's current health program in terms of its breadth and depth as well as to realign the program to be in sync with Africa Bureau's Fragile State Strategy and Angola's transition after 30 years of civil war. The February team's findings and subsequent discussions recommended streamlining the health program to focus on the following areas: HIV/AIDS, malaria, family planning, structural reform/health system strengthening, and private sector engagement.

On June 30, 2005, Angola was announced as one of the first three countries to be included in the U.S. President's Initiative on Malaria in Africa. An interagency team conducted a rapid assessment of the status of malaria prevention and treatment interventions in Angola during the same timeframe as the health system assessment (August 8–18). The two teams coordinated data collection and interviews.

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.² Its growing population is estimated at 14–17 million inhabitants, of whom about 60 percent are less than 18 years old.

The country is multicultural and multi-linguistic. More than 18 national languages are spoken, and modernity and ancestral ways of life coexist. Politically and administratively, Angola is divided into 18 provinces, 164 municipalities, and 557 communes.

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. The two largest groups to emerge during this time were the *Movimento Popular de Libertacao de Angola* (Popular Liberation Movement of Angola) and the *Uniao Nacional para la Independencia 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. 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 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 and were adopted to serve the interest of the ruling parties.

Not surprisingly, Angola falls near the bottom of most global measures of socio-economic development. The U.N. Development Program's (UNDP's) most recent Human Development Index places it 166 out of 177 countries. While the World Bank estimates average per capita income at $740, relatively high for SSA, Angola's Poverty Reduction Strategy notes that 68 percent of the population lives below the poverty line of $1.70 per day, with 28 percent living in extreme poverty on less than $0.70 per day. Annex H presents a series of comparative indicators for Angola and SSA: economic, governance, health financing, human and physical health resources, pharmaceutical, private sector, and health information systems (HIS).

The tragedy is that Angola is an enormously wealthy country. Angola is the world's fourth largest producer of rough diamonds; diamonds represent 95 percent of non-oil exports, and production is expected to reach $1billion in 2005, with Angola's diamond deposits still largely untapped (Partnership Africa Canada 2004). More importantly, Angola is the second largest oil producer in SSA and the seventh-largest supplier to the United States. Production currently stands at 1.6 million barrels per day and is rising. Oil accounts for almost half of gross domestic product (GDP) and about 75 percent of government revenue. It, along with the potential that a stable, prosperous Angola has for deepening stability and spurring economic growth in the region, gives the United States a strong reason to be a stakeholder in Angola's stability and prosperity.

2.2 Health

2.2.1 Health Status

Angola's health indicators are some of the worst in SSA. The infant mortality rate is 154 per 1,000 live births, and the under-5 mortality rate is 260 per 1,000 live births (Ministry of Planning [MOP] and UNICEF 2003). The total fertility rate is estimated to be 7.2 births per women, and average life expectancy is only 40 years. 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 (USAID 2005). 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 the primary health care (PHC) services, and through better practices and care at household level (Ministry of Health [MOH] 2004b). Malnutrition is the main associated cause of mortality. The rate of maternal mortality was estimated to be between 900 and 1,300 maternal deaths per 100,000 live births, which is 12 times higher than in other developing countries (MOP and UNICEF 2003). Contraceptive prevalence nationally is estimated to be only 6 percent among women age 15–49 who are married or in de facto unions (MOP and UNICEF 2003). Higher contraceptive prevalence (17 percent) was found in three municipalities in Luanda (Management Sciences for Health [MSH] and Consaúde 2002). These health indicators reflect a series of contributing factors such as lack of access to health services (see Table 1), water, means of excreta disposal, personal and food hygiene, food security, housing, household income, and health care knowledge and practices in communities and households.

Table 1. Health Service Indicators

Indicator	Measure	Angola			Sub-Saharan Africa		
		Source	Year	Data	Source	Year	Data
Doctors in the public sector	Doctors per 100,000 inhabitants	MOH WHOSIS	2000[a] 1997	5 7.7	HDR WHOSIS	1991 1995-2003	32 16
Access to drugs	% of the population with access to essential drugs	WHO	2001	20			
Vaccination coverage for DPT (3rd dosage)	% of children 12-23 months vaccinated	MICS	1996 2001[b]	24 34	SOWC [c]	1999	46
Vaccination coverage for polio	% of children 12-23 months vaccinated	MICS	1996 2001[b]	28 63	SOWC [c]	1999	48
Deliveries in health facilities	% of deliveries attended by trained health personnel	MICS	1996 2001[b]	22 45	SOWC [c]	1995-2000	39
Pre-natal consultations	% of pregnant women who attend one or more pre-natal consultations	MICS	1996 2001[b]	64 66	SOWC [c]	1995-2000	64
Contraceptive use	% of women of reproductive age who use any method of contraception	MICS MSH	1996 2001[b] 2002[d]	8 6 17	SOWC [c]	1995-2000	22

Source: adapted from Vinyals 2002

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), MSH = Management Sciences for Health

a) Estimate based only on doctors in the National Health Service, as published in *Anuário Estatístico do MINSA* (MOH 2000).

b) MICS 2001 (MOP 2003) only covered areas accessible during the war.

c) UNICEF (2002).

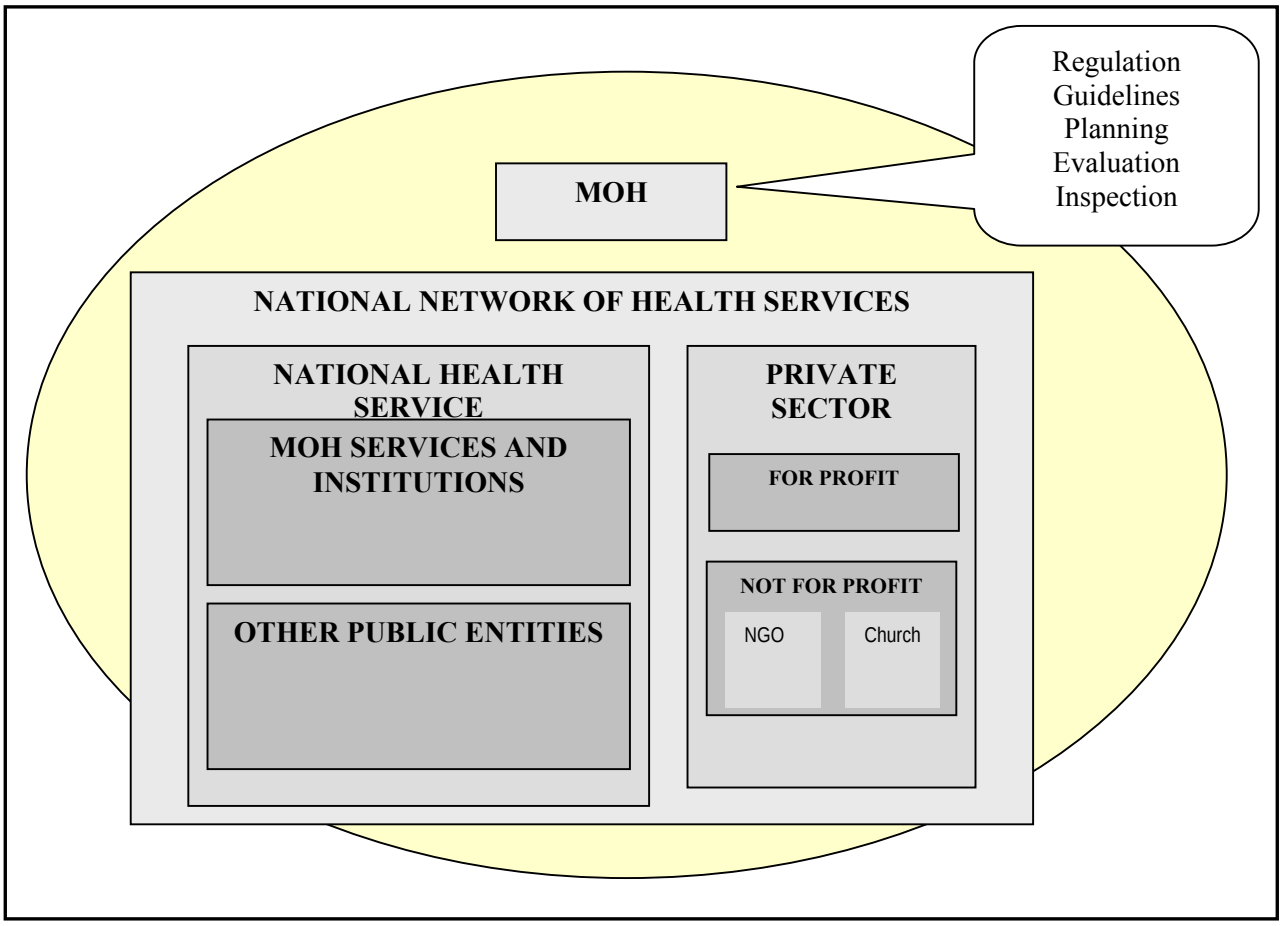
d) Survey (MSH and Consaúde 2002) covered only three municipalities in Luanda province.

Environmental health problems are significant. For example, a 1998 survey indicated that only 56 percent of the population of Luanda had access to piped water at home or from public pipes, and 42 percent bought water from private vendors who charge high prices compared to the tariffs on piped water. The 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 (MOH 2004b) observed that "…environmental causes are more important than biological causes in determining the mortality of Angola children."

2.2.2 Health System

As defined by the MOH, Angola's health service system consists of the ministry and the national service delivery network of both public and private providers (see Figure 1). The public health system was decentralized in 2001 as part of a broad government reform. The MOH's role is defined by law to focus on regulation, technical guidelines/orientation, planning, evaluation, and inspection. The MOH carries out its technical guidance role through a variety of national health programs, most of which are heavily dependent on external assistance (e.g., malaria, epidemiological surveillance, expanded program of immunization (EPI), reproductive health, nutrition, essential medicines, tuberculosis (TB)/leprosy, and integrated management of child illness (IMCI). The provincial government is responsible for provincial and municipal hospitals, health centers, and health posts, though, as will be explained in the health financing section, funding flows do not exactly match responsibility. The municipal government-level role is not well defined and capacity is reportedly weak.

Figure 1. National Health System



Source: Republic of Angola, MOH (2005)

Angola's health service delivery infrastructure was damaged during the long civil war, and reconstruction is in process. Health service delivery is divided into three levels of care (primary, secondary, and tertiary) corresponding to levels of government (national, provincial, and municipal):

- Primary care (municipal level) consists of approximately 250 municipal hospitals and health centers[1]; 729 to 926[2] health posts, an unspecified number of company health units, and community health agents.

- Secondary care (provincial level) consists of provincial hospitals across the 18 provinces. There are also an unspecified number of private, mostly religious, hospitals.

- Tertiary care (national level) consists of 27 to 100 national and specialized hospitals.

Angola has an estimated 850 doctors and 16,0376 nurses employed in the public health system. Total doctors per 100,000 inhabitants is estimated to be 7.7, which is low compared to the SSA average of 16. On the other hand, the number of nurses, at 144.5 per 100,000 inhabitants, is higher than the SSA average of 79 nurses per 100,000.

Total expenditures on health are estimated to be 5 percent of GDP in Angola, about the same as other SSA countries. However, government expenditures on health are 4.1 percent of total government expenditures, which is low compared to the SSA average of 9.5 percent. All government health expenditures flow to public sector service delivery and administration, and national health programs. There is no national health insurance or social security system.

[1] The law defines the difference between a municipal hospital and a health center in terms of facility characteristics and staffing; however, among actual facilities, the distinction is blurred. The MOH is planning to conduct an inventory of all facilities to have a more accurate number and definition.
[2] Different numbers of facilities are cited in different MOH publications.

3. Methodology

3.1 Framework for the Health Systems Assessment Approach

The current assessment used an approach developed in *Mainstreaming Health Systems Strengthening Initiative: Health Systems Assessment Approach*. *Draft Framework.* A revised version of the framework, with lessons learned from the Angola assessment, is forthcoming.

3.2 Description of Assessment Tools

A PHR*plus* design team in collaboration with RPMplus, QAP, and other Health Systems Division projects developed a set of assessment tools organized into six health system function areas or modules: (1) stewardship/governance, (2) health financing, (3) human resources and health facilities, (4) pharmaceuticals, (5) private sector engagement, and (6) health information systems. In addition, there is a core/contextual module that is meant to provide background information for the assessment. Each module (other than the core module) is divided into three components of increasing level of assessment effort. The first component consists of 10-15 quantitative indicators that users are to answer from international secondary data sources. The second component consists of 15-20 questions or indicators to be answered by consulting country reports and other secondary resources. The third component consists of 15-20 questions or statements that users are to answer based on interviews with stakeholders.

3.3 Pre-assessment Desk Research

The first phase of the Angola assessment consisted of desk research. Background documents (see Annex A) about the Angola health system were identified via internet research, recommendations from USAID/Angola, and Dr. Figueiredo, the local Angolan consultant (and an author of this report). Data for Component 1 indicators were collected and compared to the corresponding figures for sub-Saharan Africa (see Annex H). In addition, the design team drafted a final assessment report outline and identified four areas of consideration into which assessment findings and final recommendations would be organized: (1) USAID/Angola priorities, (2) USAID Strategic Framework for Africa, (3) donor mapping, and (4) priorities of the government of Angola (not in order of importance). Documents delineating the four areas were identified and collected.

3.4 In-country Key Interviews

Preparation. A team of three assessors was identified to conduct Components 2 and 3 of the assessment. Each assessor was responsible for collecting data for two modules, assigned according to assessor background. In preparation for the in-country assessment, the assessment team participated in two meetings before the assessment. The purpose of the first meeting was to review and discuss the modules with the design team, and the second was to plan assessment strategy and logistics, and draft

a detailed schedule for the two-week in-country assessment period. Each assessor assembled a list of interviewees, mostly by function and title, which a design team member combined into a single list. The local Angolan health consultant conferred with USAID/Angola to identify stakeholders and experts corresponding to the interviewee list and set up an interview schedule.

In-country assessment. Over the course of 14 days, the in-country assessment team interviewed numerous stakeholders at the national and provincial health service delivery levels (see schedule on next page). Responses were hand-recorded by the interviewer in notebooks, as were relevant comments. Categorical response data were hand tabulated and narrative responses were examined for identification of patterns across stakeholders. Each assessor summarized findings for his or her assigned modules, and then together the team summarized the results, highlighting key findings across health system performance indicators, and developed recommendations. Findings and recommendations were presented first to USAID/Angola and then to a workshop of stakeholders, who included representatives from USAID/Angola, the Ministry of Health, donors, private sector, and nongovernmental organization (NGO) community.

Angola Health System Assessment Team TDY Schedule August 6–19, 2005*

Sat	Sun	Mon	Tues	Wed	Thurs	Fri
6 Team lunch meeting 3:00 Meeting with Paula and Judy	7 2:00 Team meeting to review technical discussion on health systems strengthening (presentation)	8 8:00 USAID 9:00 Dr. Fortes, MOH Infectious Disease 10:30 UTCAH (Tech Unit for Assistance Coord.) Lunch with USAID 14:00 Pick up rental car 15:00 Dra. Teresa Cohen, National Assembly deputy	9 8:30 Review draft presenta-tion for USAID staff training 14:30 Dra. Adelaide, National Director of Public Health 15:00 Dr. Bastos, Angolan Medical Organization 17:00 Diana Swain, USAID mission director	10 8:00 USAID security briefing 9:00 Isilda Launda, provincial director of health 12:30 Dr. Van-Dunem, vice minister, MOH 14:00 CONGA (Network of Intl NGOs), Christian Children's Fund, Mary Daly 16:00 Matthew Olins, U.N. Technical Coordinating Unit 17:00 Cicci pharma importer	11 8:00 Mauricio, National Health Inspection (HIS) 10:00 Ana Vaz, director of National Epidemiological Surveillance 10:30 NGO meeting 11:00 Mtgs with Dra. Aida, Child Health/IMCI, Dr. Manassas, MOH Essential Drugs 14:00 Private large employers meeting 16:00 NovoBanco	12 9:00 U.N. Development Program 11:00 Dr. Daniel, National Drug Program 15:00 Jacques Mataieu, U.S. Centers for Disease Control & Prevention 16:30 Cabinet of Statistics and Planning (GEPE) Team check-in Write-ups
13 Drafts of each subsection by 14:00 14:00–16:00 Review of subsections	14 9:30–11:00 Team meeting 11:00–1:00 Debrief malaria team 2:00–4:00 Team meeting to identify options	15 10:30 Mario Ferrari UNICEF country representative 1:30 Dr. Mariano, Americo Boa Visita Hospital 16:30 Presentation on health systems for USAID staff	16 Yogesh and Judy in Huambo 9:00 Malaria team meeting with NGOs 14:00 WHO country representative 16:00 Dr. Raul Feio, European Union	17 9:00 Evelize Frestas, MOH HRD 10:00 Dr. Paula, HIS and 9 municipal representatives 13:00 Susan Grant, Save the Children Yogesh and Judy back from Huambo 15:30 Leave for Esso reception	18 7:30–12:30 Catherine and Ya-Shin visit helath center in Cucuaco 14:30 Mtgs with UNICEF, Provincial health directorate/Luanda 15:30 Debrief USAID 17:00 Debrief Ambassador Cynthia Efird Prep for stakeholder meeting	19 8:30–14:00 Stakeholder workshop at Hotel Tropico 14:00–15:00 team meeting 15:30 Debrief USAID

*Schedule of Visit to Huambo Province by Judy Weigert and Yogesh Rajkotia

Tuesday, August 16, 2005
08:30: Arrive in Huambo
09:00: Meeting with the Provincal Director of Health Elias Finde
11:00: Visit to the Cacilhas Health Center, meeting with TBA and Soba
13:00: Visit to the Central Hospital of Huambo: Director João Chicoa
14:30: Lunch
15:45: Visit to the Clínica Arquidiocesana (private)
16:30: Visit to the Refugee Camp
17:30: Visit to the Informal Market/ Pharmacy
18:00: Cocktail with NGOs and U.N.
21:00: Sleep at Advance Africa Guest House

Wednesday, August 17, 2005
08:00: Review of visit
09:00: Visit to the Municipal Hospital of Cahala.
10:00: Depart Luanda

4. Strengths and Weaknesses of the Angolan Health System

This section describes and analyzes the strengths and weaknesses of the Angolan health system. Because a country health system is broad and complex, the analysis breaks the system down into six subtopics: governance, financing, human resources and facilities, private sector, pharmaceutical sector, and health information systems. The section ends with a summary of findings across all the subtopics.

4.1 Governance

USAID classifies Angola as a "fragile state," which calls for a country strategy that supports stability, capacity development, and reform. In accordance with USAID/Africa Bureau's Strategic Framework, the Mission has assessed the sources of fragility in Angola and identified weak governance as a key issue. Therefore, governance is a particularly important element for the assessment of the Angolan health system.

Governance is broadly defined as the set of traditions and institutions by which authority in a country is exercised, including (1) the process by which governments are selected, monitored, and replaced, (2) the capacity of the government to effectively formulate and implement sound policies, and (3) the respect of citizens and the state for the institutions that govern economic and social interactions among them. Governance in the health sector specifically is "The careful and responsible management of the well-being of the population; the very essence of good governance" (WHO 2000) and includes:

- The continuous process of developing, revising and enacting health policies and regulations
- Raising awareness and mobilizing communities, institutions and individuals to promote effective health policies and practices
- Assuring an environment in which the government, NGOs, private enterprises and individual health practitioners can operate effectively and efficiently

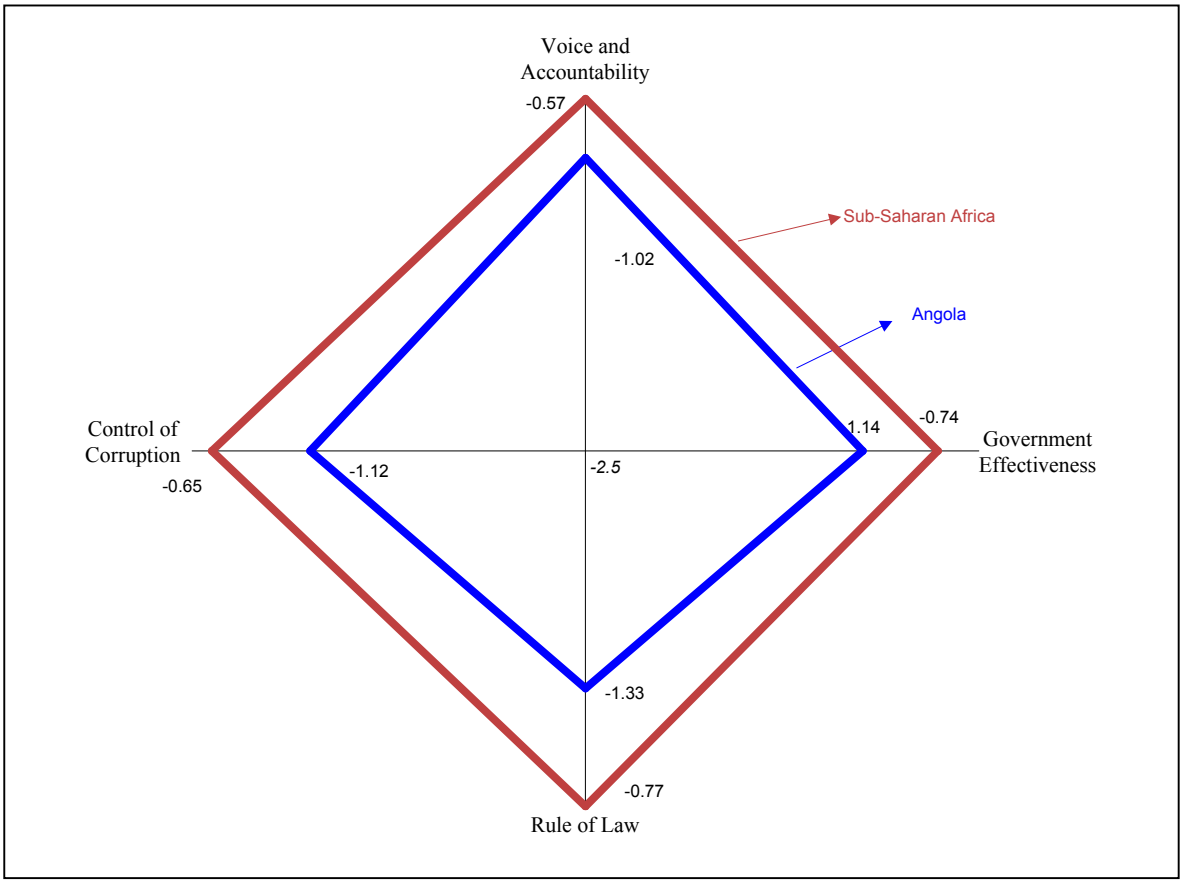
In the following sections, the strengths and weaknesses of health system governance in Angola are assessed along five dimensions: health information capacity, regulation, policy formation and planning, external participation and partnerships, and accountability.

4.1.1 Background

Overview

The quality of governance overall in Angola is weak, though it has improved slightly in the last few years. (See Figure 2, which compares Angola to all of sub-Saharan Africa in terms of various governance indicators.)

Figure 2. Selected Governance Indicators for Angola and SSA



Source: Transparency International 2004

Almost 30 years of civil war hampered the evolution of democratic practices and institutions, and severely limited pubic spending in social sectors. Public revenues from oil and diamonds account for half of GDP but are not fully accounted for, despite multiple initiatives[3] in this area by the Ministry of Finance, International Monetary Fund (IMF), and the World Bank. There is a pattern of regressive allocation of public assets and resources to an elite minority, at the expense of the larger society. For example, from 1997 to 2001, public expenditures on the Overseas Evacuation Fund

[3] For example: a new, still incomplete, financial management and information system (SIGFE); the Public Finance and Modernization Program launched in 2002 and ongoing; and the World Bank's Economic Management Technical Assistance Project.

(*Junta Nacional de Saúde*) to evacuate the elite for overseas medical services consumed 13 percent of the total public health expenditure, compared to 17 percent for primary health care (Vinyals 2002). Angola does very poorly on indicators taken from the Corruption Perceptions Index (CPI), both in terms of absolute value and compared to SSA. The indicators for quality of law and contract enforcement, police, and the level of violence are particularly low.

Decentralization

To assess governance in the health sector it is necessary to understand the impact of decentralization. As part of a broader administrative reform of the state in 2001 (*Reforma Administrativa do Estado*), all service delivery was decentralized to provincial governments run by governors appointed by the president (see Table 2). The MOH was left in charge of policy/planning, regulation, training, national health programs, and procurement of essential drugs. There has been greater decentralization of health financing than of administrative responsibility, so budget flows are not consistent with the administrative hierarchy. National and provincial hospitals and the provincial governments receive their budget allocations directly from the Ministry of Finance (MOF), even though the MOH is supposed to oversee national hospitals, and the provincial government is supposed to oversee provincial hospitals. Separation of budget control from administrative responsibility interferes with governance and integration across levels of care; nevertheless, the direct budgeting from the MOF to the hospitals has resulted in an increase in funds for these facilities.

Table 2. Angolan Political Structure and Public Health Service Delivery System by Level

Level	Political Structure		Health System[1]	
	Executive	Legislative	Governance	Health Facilities
National	President: Took office in 1979; elected in 1992 Ministries by sector like the MOH	National Assembly: 220 deputies elected in 1992. Parliamentary commission on health, environment, and social affairs	Ministry of Health responsible for policy/planning, regulation, training, public health programs, procurement of essential drugs	27 to 38 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 municipal hospitals, health centers and posts.	62 provincial hospitals
Municipal (163)	Administrator appointed by the governor Municipal section for social services (health, education, other)	Municipal councils (not in all municipalities)	Municipal health sections have line responsibility for health centers and posts, but no budget.	Approximately 250 municipal hospitals and health centers
Commune (532)	Administrator appointed by the governor	Communal councils in some communes		725 to 926 health posts

[1]Does not include the military health system, which accounted for 6 percent of public health expenditures in 2001

4.1.2 Health Information Capacity

At the national level, MOH documents for health planning, like annual sector plans and the five-year development plan, present useful, relevant health data to substantiate proposed programs. However, authority over the allocation of public health financing is concentrated in the MOF and provincial governments, which do not appear to consider health data in decision making. For example, Angolan health statistics point to the need for investments in public and primary health care, but tertiary care (national and provincial hospitals) consistently receives the majority of public health funding. At the provincial level, out of 18 provinces, only Luanda province has a health strategy that includes health data.

The health information system is underfunded (e.g., inadequate funds to print/copy data collection forms across all facilities), inefficient (multiple, parallel data flows), and underutilized for policy and planning. Vertical information systems that rely heavily on external assistance, like epidemiological surveillance, reportedly function well. The HIS is largely one-way flow of data from the service delivery sites up to the national level with little capacity or incentive at any level to use the data for decision making.

There is limited population-based data due to the lack of government commitment and, until 2002, lack of security to conduct household surveys. The last census was 1970. Household surveys with health data include the National Institute of Statistics' (*Instituto Nacional de Estatistica*, INE) Survey of Household Conditions in 1993 (5,783 households in five provinces), the State of Maternal and Child Health in the Districts of Cazenga, Cacuaco, and Viana: Baseline Survey in 2002 (1,642 households in three municipalities) implemented by USAID's Strengthening Maternal and Child Health Services Project, and the INE- and UNICEF-implemented Multiple Indicators Surveys in 1996, 2001, and 2003. Angola has never conducted a Demographic and Health Survey (DHS).

There is a broader problem of lack of information and awareness among the general population that is an obstacle to good governance and accountability. For example, one NGO reported doing a community meeting and the participants were surprised to learn that Angola had oil reserves and significant oil revenues.

4.1.3 Regulation

The "Basic Law on the National Health System" was approved in 1992 and provided the framework for further legislation and regulation. Legalization of private sector health providers and not-for-profit entities was passed in 1992 (Republic of Angola 1992). Decree 2/00[4] defines the organization and functioning of the MOH, provincial, and municipal health administration, and Decree 54/03 defines each type of public health facility. The level of detail may be excessive in some cases, for example, defining the number of staff for every MOH department, and therefore constrains management. In other cases, laws and corresponding regulations lack detail. For example, those regarding user fees at public health facilities do not specify amounts, collection procedures, or exemption policies. Generally, people interviewed at the national level said there is a gap between laws and implementation. For example, the actual size and structure of municipal hospitals and health centers is thought to vary significantly from the legal definition. Another example is the Decree 2/00 article 21, establishing municipal departments of health, which has not been implemented in many municipalities.

[4] The second number, after the slash, refers to the year the law was established.

There is ample legal framework for regulation of the public and private health sectors. The MOH's General Health Inspection unit is responsible for developing and enforcing regulations. It has a staff of inspectors. Each province also has an inspection department. Luanda province has 34 inspectors who are actively visiting public health facilities in an effort to inventory and reclassify them. The regulatory function as currently exercised is very basic (see if the facility is functioning, water/electricity, number of beds), and not a quality assurance initiative that would affect how services are delivered. On the other hand, the private sector is highly regulated across all economic sectors in terms of bureaucratic requirements to the point of being a barrier to market entry:

- Company start-up comprises 14 steps that take an average of 146 days and cost the equivalent of 884.6 percent of gross national product per capita.
- Labor laws restrict hiring, firing, and working hours.
- Regulations governing registration of property can take 335 days.
- Legal procedure for enforcing contracts is bureaucratic (47 procedures), but not considered effective (World Bank 2004b).

4.1.4 Policy Formation and Planning

Power is concentrated in the executive branch, and the national assembly is quite weak. The national assembly has a Commission for Health, Environment, and Social Action that is not very active. However, two private sector entities, one NGO and the Angolan Medical Association, cited examples of working with the commission to develop decrees on health.

The MOH has issued, with some external assistance, good planning documents like the Health Sector Program 2005-2006, the Annual Sector Program 2005, the Sector Development Plan for 2000-2005, and the Accelerated Program to Reduce Child and Maternal Mortality. These documents present noble, measurable (albeit ambitious) goals focused on Angola's priority health problems. However, there is a gap between plans/intentions and actions, including resource allocation. Government representatives who were interviewed readily acknowledge gaps, and several commented along the lines of "we have beautiful plans but we do not implement them." For example, budget execution is surprising low. Between 1997 and 2001, the MOH executed only 60 percent of its health budget on average. An exception has been the medical evacuation program that consistently executes a higher percentage of its budget (Vinyals 2002). Resource allocation strongly favors hospital care and overseas treatment for a minority over primary and public health care, in contradiction of sector goals to reduce infant and maternal mortality. People interviewed in and out of government most often blame weak implementation on the lack of human capacity (especially leadership) and financial resources. Another factor is political will. There is an official policy and planning process that is relatively participatory in terms of donor participation, and produces reasonable policy direction. In parallel is an unofficial process that reflects the concentration of political power and other priorities for resource allocation (e.g., the delay of essential drug procurements). Decentralization was not cited as a cause of the MOH not being able to implement its policies and programs in the service delivery system.

4.1.5 External Participation and Partnerships

There are at least 16 multi- and bilateral programs in the health sector (see Annex F), plus numerous international NGOs. Several of these programs include health system strengthening activities (see Annex G) and representatives interviewed shared similar perceptions of priority areas:

- Increase the utilization and quality of PHC services
- Shift from top-down planning to data-driven, bottom-up planning
- Shift from strategic planning to operational and mirco-planning that facilitates implementation and action
- Increase supervision of public health workers, especially formative supervision
- Integrate the vertical public health programs at the provincial level and below
- Expand sharing of resources across the donor-funded vertical public health programs to maximize efficiency (training events, vehicles, etc.)

While external funding of the health sector in Angola is less significant as a percentage of total health financing compared to other SSA countries (8 percent in Angola versus the SSA average of 20 percent), there is still a significant need for donor coordination. Previous assessments (including Frankel 2003), as well as MOH, donor, and NGO representatives all cited the need to improve coordination in the health sector. If good government/donor/NGO coordination is defined as consistent, dynamic, productive, government-led, with the right people meeting at the right level and effective at achieving synergies, then neither of the existing mechanisms are functioning satisfactorily:

- Technical Unit for Assistance Coordination (known as UTCAH, for its Portuguese name) is the official government agency responsible for NGO coordination as well as donor coordination. It is part of the Ministry of Assistance and Social Reintigration (MINARS). UTCAH maintains a database of all NGOs, prepares quarterly progress reports on NGO and government assistance, and hosts high-level (e.g., ambassadorial-level) meetings each quarter, but the meetings are not strategic. UTCAH is not specific to the health sector but occasionally hosts sector meetings. UTCAH is reportedly weak at the provincial level. UTCAH receives technical assistance from the U.N. Transitional Coordination Unit (TCU), formerly the Coordinating Agency for Humanitarian Assistance (OCHA).
- Inter-Agency Coordination Committee (ICC) was established for polio, but has broadened its scope since the 2004 launch of the MOH's Accelerated Program to Reduce Maternal and Infant Mortality. For this program, the ICC is the mechanism for coordinating partners and accompanying activities at the national level, led by the vice minister of health. The intended participants are the heads of departments and programs involved, the representatives of the World Health Organization (WHO), UNICEF, U.N. Population Fund (UNFPA), USAID, European Union (EU), one representative of national NGOs, another of international NGOs, and another of the churches. The ICC is said to be having regular weekly meetings with the vice minister, albeit without the broad participation listed above (e.g., EU and USAID are not attending).

4.1.6 Accountability

As discussed earlier, Angola is in transition, with limited experience of democratic practices except for the 1992 elections that dissolved into the resumption of civil war. General elections for the national assembly have been announced for 2006. The presidential elections are likely to be held in 2007, though there has been no official announcement. Unfortunately, a democratic process for representation at the municipal and provincial levels is not on the immediate horizon. Given that no one in Angola has experienced an election without violence, successful 2006 elections are defined by some as a peaceful, participatory exercise. A change in the balance of power is not expected.

At the national level, donors and international organizations exercise some influence to promote public accountability on health issues through dialogue, technical assistance, and investment in priority health programs. Given its enormous natural resources, Angola is far less beholden to external assistance than are many other countries. This increases the importance of donor coordination and public partnership.

At the subnational level, decentralization did not effectively increase accountability given that provincial governors are appointed by the president and municipal administrators appointed by the governor. There are some examples of increasing accountability through the participation of community representatives or NGOs on municipal councils (Fustukian 2004). In general, Angolan NGOs have credibility with the community and are a potential avenue for greater accountability. As mentioned earlier, lack of information among the population is an obstacle.

Civil society does not have an effective "voice" at any level. Angolans are not accustomed to making the public sector accountable, nor is it considered safe to "stick your neck out" in terms of organizing opposition to the government. On the other hand, NGOs working at the community level find that civil society "works" in the sense that, despite the war and poverty, Angolans are willing to work cooperatively, and even voluntarily, to make concrete improvements within their sphere of influence.

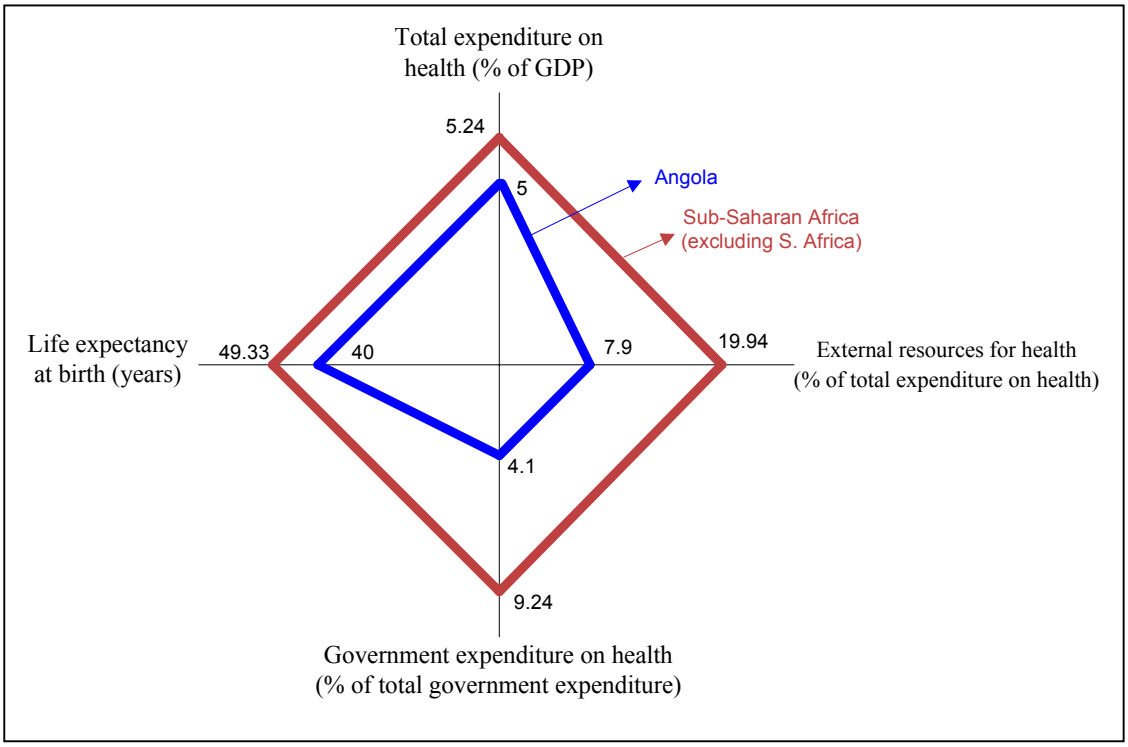
4.2 Health Financing

4.2.1 Overview

In 2005, total health expenditures are projected to be 5 percent of GDP, which is slightly lower than the sub-Saharan Africa average (WHO 2005). However, the Angolan government invests significantly less in health than its peers. Government health expenditures were 4.1 percent of total government expenditures in 2002, compared to 9.24 percent in the SSA region (WHO 2005). As a percentage of total health expenditures, government expenditures on health are estimated to be 41.9 percent, compared to 49.5 percent for SSA (WHO 2005). Angola appears to be less dependant on donors, with donor funds representing 7.8 percent of total health expenditures in 2002, compared to 20.4 percent for the SSA region (WHO 2005). Thus, with government and donor funding less than the SSA average, it appears that private sector sources of health expenditures are significantly higher in Angola than the SSA region. One can deduce that roughly 50 percent of total health expenditures are private. Private expenditures are composed of out-of-pocket payments by households and private employer expenditures on health services for their employees. As will be discussed later, private expenditures in Angola may primarily be user fees for public care and out-of-pocket payments for private care and medicines. Interestingly, life expectancy in Angola is significantly lower than the

SSA average (40 vs. 49.33), though factors other than health financing have likely contributed to this (World Bank 2004). Figure 3 describes these relationships in comparison to SSA region.

Figure 3. Comparison of Key Health Finance Indicators, Angola and SSA



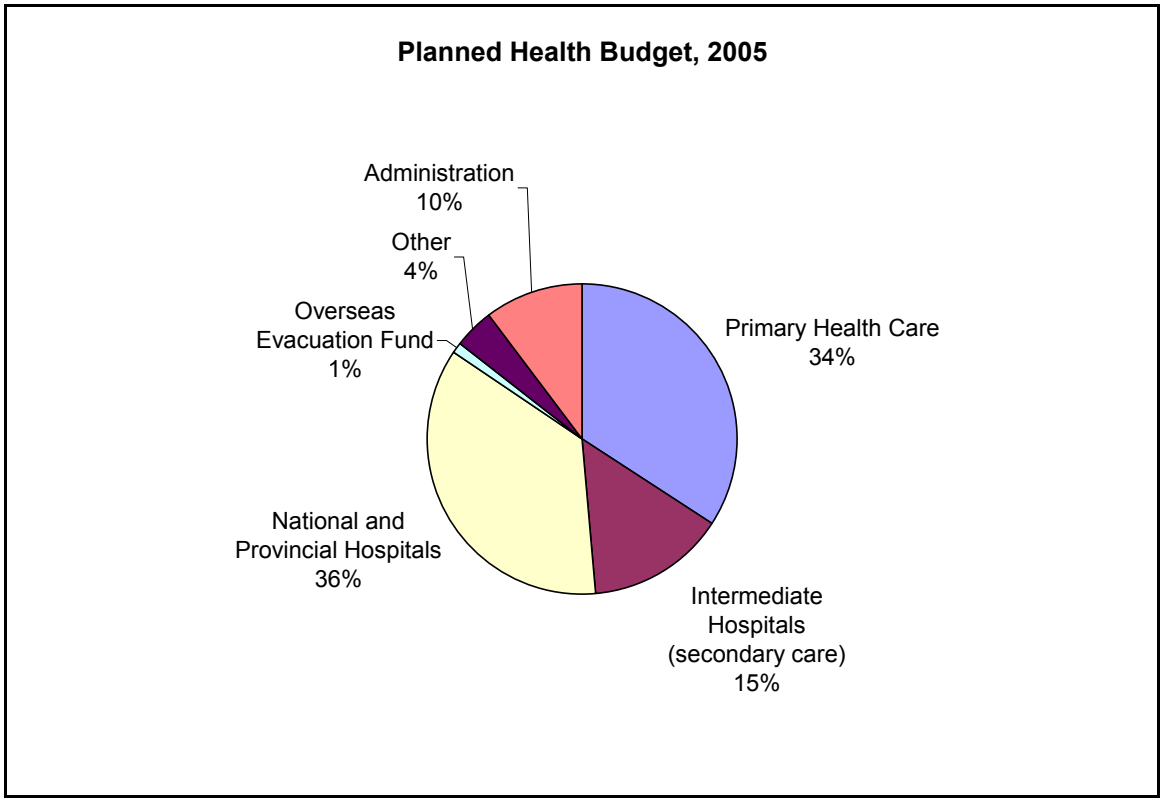
Source: WHO 2005, World Bank 2004

Angola does not have any health insurance, such as social health insurance, private health insurance, or community-based health insurance. However, all large companies provide some health service coverage for their employees. The covered population may also extend to employees' dependents and even employees of subcontractors. Health coverage is through on-site clinics, company-owned health facilities, or contracts with independent health facilities.

The planned government health budget in 2005 is described in Figure 4. Interestingly, the budget for PHC has been significantly increased, from an average of 17 percent in 1997-2000 to 34 percent of the total government health budget in 2005 (MOH 2005, Vinyals 2002). Secondary care has also increased during this period, from 10 percent to 15 percent of the total government health budget (MOH 2005, Vinyals 2002).

Also interesting to note, Angola recently built "Multiperfil," a state-of-the art facility intended to decrease reliance on medical evacuations. This is reflected in the 2005 budget, as the budget for overseas medical evacuation has decreased from 13 percent of the total government health budget to 1 percent in 2005 (MOH 2005, Vinyals 2002).

Figure 4. Planned Health Budget, 2005 (capital and recurrent costs)



Source: MOH 2005

Note: Primary health care includes all national programs (malaria, TB, HIV/AIDS, immunization, polio, and trypansomiasis), essential drugs, health centers, and health posts). "Administration" refers to administrative costs borne by the provincial health directorate and at central levels. "Other" refers to planning/development of new programs, funding for institutions, etc.

4.2.2 Resource Flows

The Angolan health system is highly decentralized from the central to the provincial and municipal governments. Figure 5 maps out the financial flows among these three levels. The key financing agents are the MOH, MOF, provincial governments, and patients. Donor funding is not captured in this depiction, as there are many donors operating at all different levels of the system.

As described in Figure 5, there are three types of resource flows in the Angolan health system: capital investments, non-salary recurrent budget (operating budget), and salaries. Capital investments are the resources that have a useful life of more than one year, and therefore are not consumed or replaced annually. Examples include reconstruction of hospitals, equipment, vehicles, etc. Recurrent (or operating) costs are expenses associated with inputs that will be consumed or replaced in one year or less. Examples include salaries, drugs, supplies, utilities, and fuel. For this discussion, we will separate salaries from recurrent costs. The share of each component can be found in Figure 6.

Figure 5. Findings: Health System Resource Flows

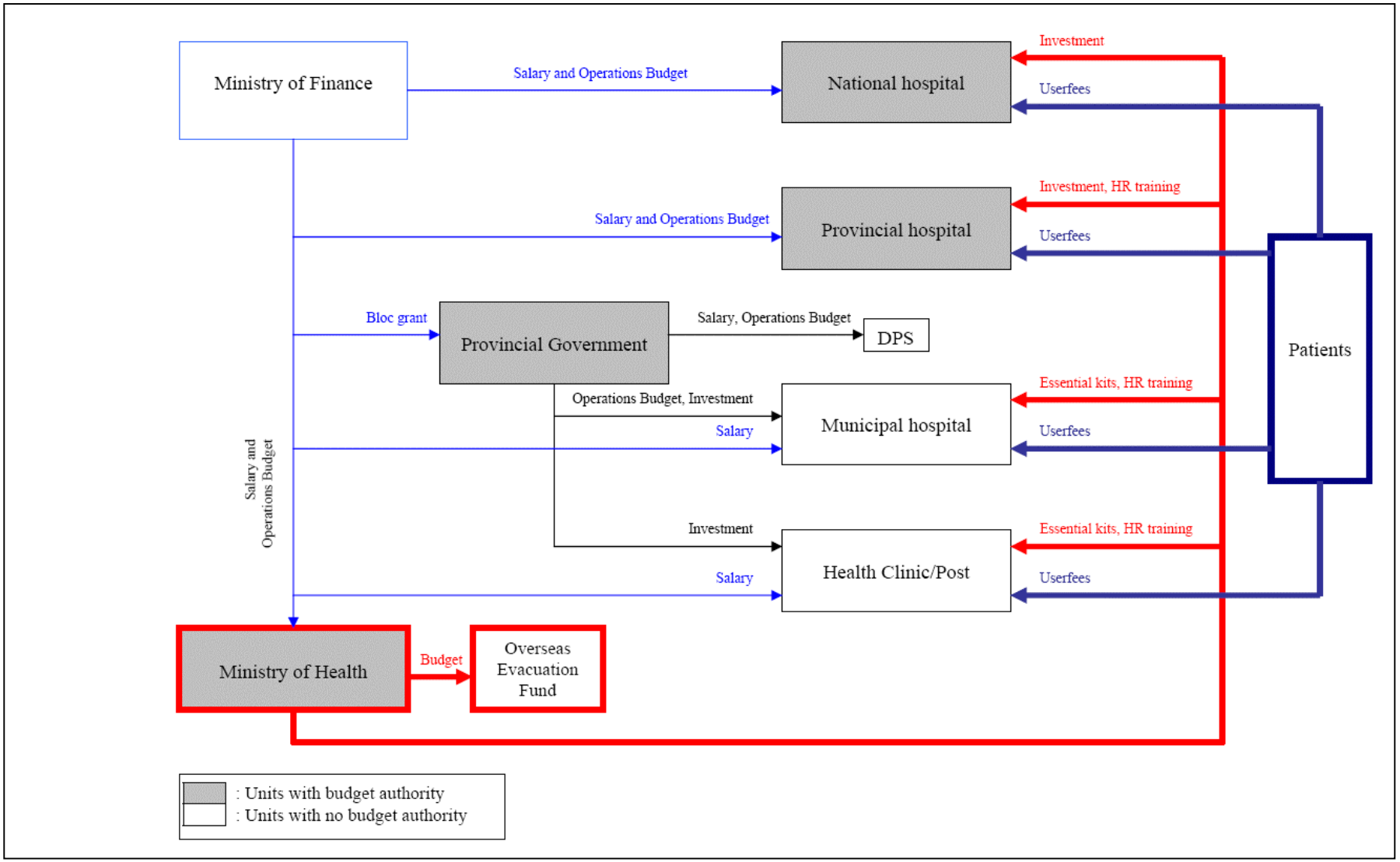
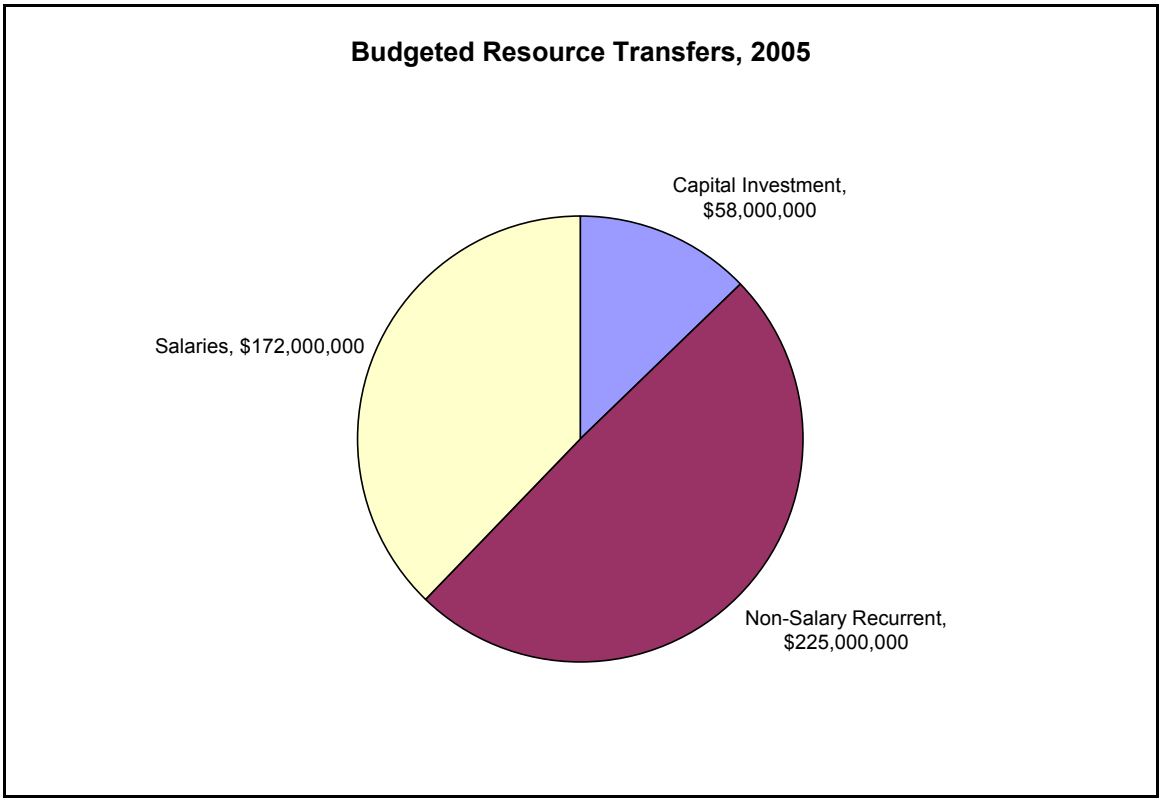


Figure 6. Budgeted Level of Resource Transfers, 2005



Source: MOH 2005

All levels, from national hospitals to health posts, receive a salary support budget that is independent from other recurrent costs. The MOH, national hospitals, provincial governments, provincial hospitals, and municipal hospitals receive a line-item budget; all but the municipal hospitals have budgetary authority. Budgetary authority, in this case, is defined as the ability to spend funds autonomously, without seeking authorization from an overseeing institution. Municipal hospitals do not have budget authority – they must obtain signature authority from the provincial government for each budget expenditure.

Flows from Ministry of Finance

The MOF allocates budgets to four entities (all of whom have budgetary authority): the MOH, national hospitals, provincial hospitals, and provincial governments.

Flows from Ministry of Health

In 2005, the MOH received a budget of US $233 million, which represents 39 percent of total government health expenditures (MOH 2005). With these resources, the MOH allocates two types of resources: non-salary recurrent costs and capital investment.

The MOH offers capital investments to national and provincial hospitals. The key non-salary recurrent costs that the MOH offers 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 municipal 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.

Flows from provincial governments

Provincial governments receive their funds directly from the MOF. These funds are used to purchase and transfer capital (such as building infrastructure, ambulances) to municipal hospitals, health centers, and health posts. In most cases, provincial governments also conduct all procurements on behalf of municipal hospitals.

All health centers, health posts, municipal hospitals, and provincial hospitals report to and are dependent on the provincial government for resources. Provincial hospitals receive their budget from the MOF.

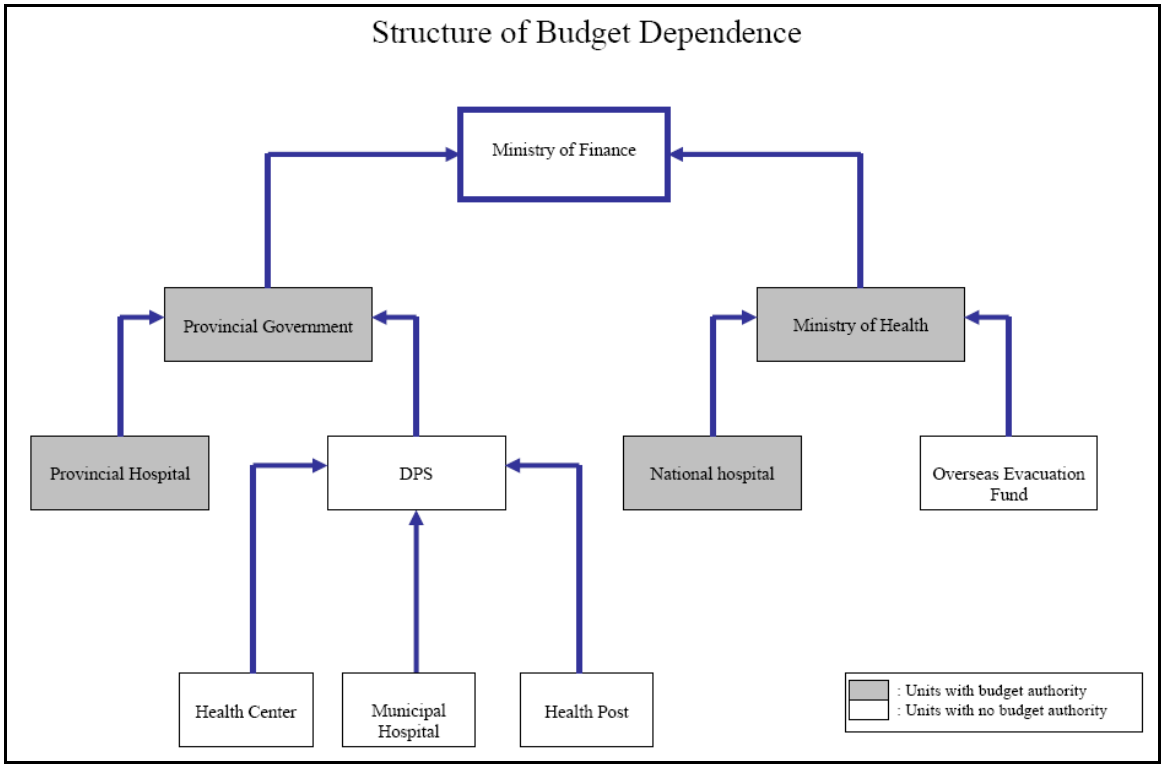
The provincial government also funds the provincial health directorate (DPS in Portuguese). The DPS is responsible for managing all health activities for the province. It has three major departments: (1) department of public health and epidemiological control; (2) department of medical assistance and 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 to develop provincial health strategies.

4.2.3 The Budgetary Process

It is important to note that Figure 5 represents only resource flows. It does not represent the hierarchal structure, nor does it describe the structure of budget dependence. This is an important distinction, because some entities may receive their funds from one source but must negotiate for their budgets with another source. Thus, the power does not necessarily lie with the entity that sends the resources. As will be described later, this disconnect has begun to cause problems. For instance, national hospitals have reportedly abandoned negotiations with the MOH (their overseeing body), and instead have begun negotiation directly with the MOF (their financing agent).

Figure 7 describes the structure of budget dependence within the public health system. All budgetary decisions are made by three entities: MOF, MOH, and provincial governments. The following sections describe the process at each of these levels.

Figure 7. Budget Dependence Structure in the Angolan Health System



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

Ministry of Finance budget allocations

The MOF determines the budget allocation for all provincial governments and for the MOH. Provincial governments present the MOF with their budget request for all public sectors. These figures are then negotiated until a compromise is reached. It is important to note that the provincial budget does not come with earmarks for health, thus the level of health spending at the provincial level is at the sole discretion of the provincial government after the MOF allocates the funds.

The MOH presents its budget request to the MOF. This presentation is based on data analyzed by Cabinet of Studies, Planning and Statistics (GEPE in Portuguese), the MOH's data analysis and statistics arm. GEPE receives health information (epidemiological and budgetary) from all provinces and combines this with the needs of the national health priorities to determine the level of the MOH budget request. GEPE also tracks external assistance for national health programs, which is a significant contributor to the national priorities budget.

Traditionally, GEPE has had capacity problems that have limited its ability to produce and present the MOH's analysis of needs. The EU has since placed external consultants to help GEPE in this endeavor. Even so, our interviews suggest that the budgetary negotiation between MOH and MOF is contentious and not data-driven, sometimes overshadowed by political tensions. Moreover, our interviews with budget negotiators in the MOH suggest that the MOF does not place much importance on health and is therefore not interested in data-based, needs presentations.

As described in Figure 5, the MOH (through GEPE) and provincial governments negotiate directly with the MOF for their budgets. National hospitals must negotiate with the MOH for their budget, and provincial hospitals must negotiate with the provincial government for their budgets.

Ministry of Health budget allocations

The MOH determines the budget for the Overseas Evacuation Fund. The process by which this allocation is decided is unclear. The MOH also determines the budget for national hospitals. National hospitals present the MOH with their budget requests based on their own needs assessments. The MOH then uses this information to determine the national hospital budget, and passes this request to the MOF for disbursement.

This process has resulted in much tension between the MOH and national hospitals. Our interviews reveal that hospitals feel that they are under-funded and their needs are not considered. In 2005, the national hospitals have been in discussion directly with the MOF for next years' budget allocation, thus bypassing the MOH. According to several national hospital directors interviewed, the MOF is more sympathetic to national hospitals and are willing to ignore MOH recommendations and offer higher budget allocations. It is unclear what impact this will have on future hierarchical relationships.

Provincial government budget allocations

The provincial governor determines the budget for health centers, health posts, and municipal hospitals. However, there is no national mandate requiring provincial governments to provide resources to these facilities.

In theory, allocation decisions are based on the assessment of budgetary needs for the health posts, centers, and municipal hospitals conducted by the DPS. It is important to note that the DPS does not have authority (except in Luanda province) to allocate funds or transfer goods; its core function is to provide information for planning.

In practice, the provincial budgetary process has been highly "top-down," as most DPS units do not have the necessary capacity for effective analysis and advocacy. According to the MOH, the DPS is often unable to conduct sufficient analysis for planning. In the cases where it does, the DPS has not advocated its findings effectively to the provincial governor, thus resulting in poor allocation of funds.

In response, the EU has provided direct analytical support to the DPS in five provinces (Huambo, Luanda, Benguela, Huila, and Bie), and has helped them advocate for the appropriate budget allocations. Our interviews with DPS officials and health care providers reveal that this process has resulted in a net increase in funding for primary care, with better allocations to municipal hospitals and health centers/posts.

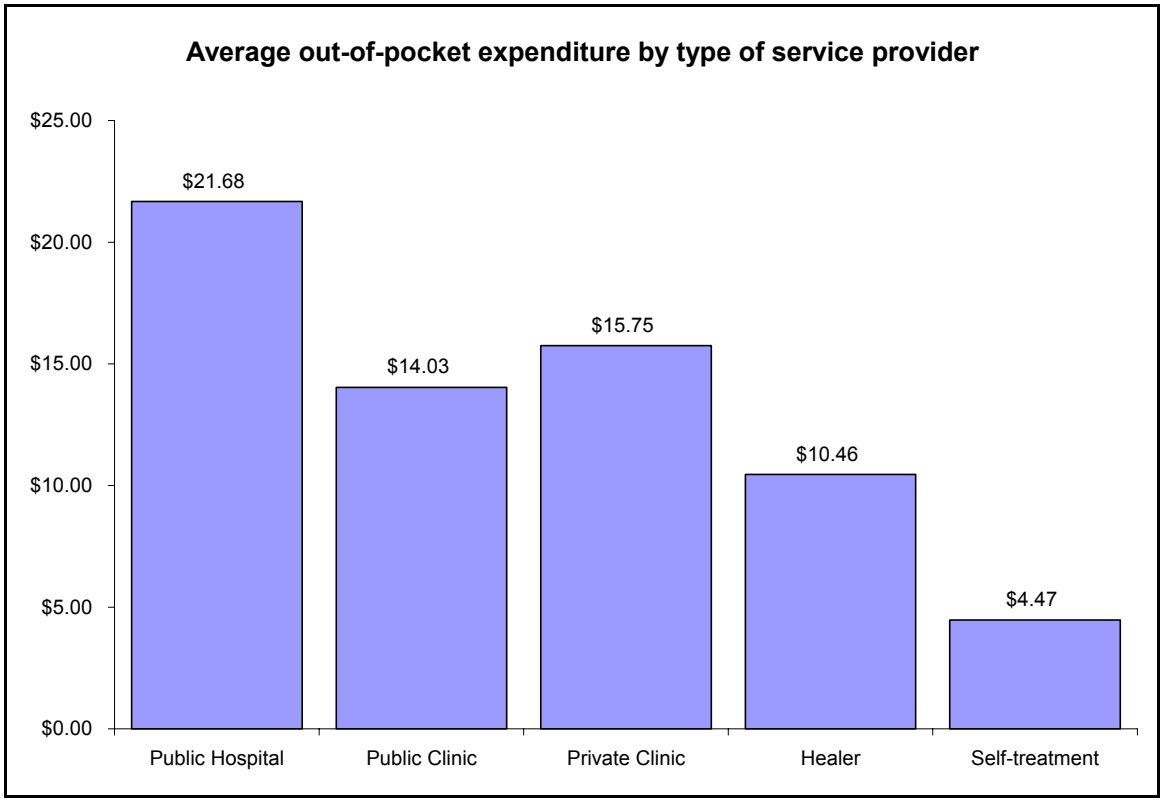
4.2.4 Out-of-pocket Expenditures

Out-of-pocket expenditures are those made by individuals and households. This section describes why out-of-pocket expenditures are needed, how they are administered, and offers suggestions about how out-of-pocket expenditures issues can be resolved as a roadmap to the team's recommendations in Section 5.

Analyzing out-of-pocket expenditures

Link between out-of-pocket expenditures and Operating costs for health clinics and posts. An analysis of the resource flows and budgetary process reveals that health centers and health posts, the key providers of PHC services, do not receive a budget or any support for non-salary recurrent costs other than the drug kits that the MOH provides irregularly. Therefore, in order to remain functional, health clinics and posts are forced to raise own-source revenue, primarily from user fees. An unpublished EU study in five provinces (32 centers, 820 patients) quoted in the MOH's biannual health plan 2005-2006 (MOH 2004a), concludes that user fees at the PHC level in Angola are one of the prime barriers to utilization. A household survey conducted in 2002 in three districts in Luanda province reveal the level of out-of-pocket expenditures for health care, for different types of provider and self-treatment (Figure 8).

Figure 8. Average Out-of-pocket Expenditure per Episode of Illness by Type of Service Provider



Source: MSH and Consaúde (2002).
Note: These data do not control for the type of illness serviced; thus, it is not valid to make cost comparisons across service providers. However, the data do show that the out-of-pocket expenses associated with health care in Angola are high, given the low income of most Angolans.

Alarmingly, there are no national laws or guidelines regulating user fees charged by public health facilities. While some provinces, such as Huambo, have been proactive in regulating user fees (providers and patients interviewed in Huambo confirmed that fees are not charged), most have not, resulting in non-uniform, and often ad-hoc, user-fee charges. While some clinics and/or hospitals

have exemptions for the poor in place, the exemptions are given through an ad hoc process at best, and through favoritism at worst.

It is important to note that, while user fees are likely a major barrier to utilization, simply banning user fees (as in Huambo province) will not solve the problem. In Huambo, this policy has left health centers without the ability to pay for electricity, fuel, and other operating supplies. Based on our visits and interviews, we deduced that health facilities have responded by simply giving each patient a list of supplies needed for his/her particular treatment, and asking the patient to go into the market to purchase them. This has led to the burgeoning of a large informal drugs and medical supplies market. It is not clear how the out-of-pocket expenses of patients purchasing their own supplies would compare to a user fee-based system. However, it is clear that one of the prime causes of user fees is the lack of operating supplies at the facilities. Thus, the focus of activities to reduce user fees should be on building a means by which the provincial governments and MOH provide the key operating supplies to health facilities.

Link between out-of-pocket expenditures and operating costs for municipal hospitals. Unlike health clinics and health posts, municipal hospitals receive a budget for non-salary recurrent costs from the provincial government. However, municipal hospitals have little voice in the preparation of their budgets, and assigned budgets do not necessarily correspond to their clinical needs. Our interviews revealed that, in some cases, municipal hospitals have received no budget. In cases where budgets are assigned, timely spending authorization is not always given by the provincial level, sometimes resulting in unexecuted budgets. Overall, municipal hospitals receive only 5 percent of the total resource flows in the Angolan public health system.

Not surprisingly, municipal hospitals, like health centers and posts, are also forced to charge user fees for PHC services in order to cover their non-salary recurrent costs. These fees have also shown to be a prime barrier to utilization (MOH 2004a). This should be of concern, given the complementary role municipal hospitals play in PHC. Activities to reduce user fees in municipal hospitals should focus on building a means to ensure provincial governments will provide adequate budgets and timely authorizations.

Addressing out-of-pocket expenditure issues

Building provincial capacity. The DPS can play a key role to increase resources from the provincial government to the facilities discussed above (health centers, posts and municipal hospitals). As described earlier, the provincial budgetary process has been highly "top-down," as most DPS units do not have the necessary capacity for effective analysis and advocacy. According to the MOH, the DPS is often unable to conduct sufficient analysis for planning. In the cases where it does conduct some analysis, the DPS has not effectively advocated its findings to the provincial governor, resulting in poor allocation of resources.

Thus, the team believes that one of the key capacity development activities to reduce user fees should focus on building DPS capacity to analyze data and advocate for provincial governments to increase resources to health centers, posts, and municipal hospitals, thus reducing the need for facilities to charge fees.

Building provincial accountability. As stated above, reducing user fees requires that provincial governments transfer adequate resources to the health facilities. In order to accomplish this, it is helpful to understand the governing structure at the provincial level.

An analysis of the structure of budgetary dependence reveals that provincial governments are key decision makers in the funding levels of provincial and municipal hospitals, health centers, and health posts. However, since the decentralization reforms have taken place, the provincial government does not receive oversight by the MOH or MOF on the allocation of these resources. While this was the intended consequence of the decentralization reforms, it was also intended that the provincial oversight function would be assumed by the municipal and citizenship level. However, the provincial governor is appointed by the president and there are no elected officials at the provincial or municipal levels. Thus, there is little incentive for the provincial government to address local concerns, especially from impoverished municipalities.

The establishment of municipal councils was intended to strengthen provincial accountability to municipalities and citizens. However, our interviews indicate that municipal governments are very weak and do not function in their role of representing their municipal constituents to the provincial level. Partly, this may be the case because municipal heads are appointed by the provincial governor.

It is the team's opinion is that the lack of local-level (health clinics/posts and patients) participation in government is a significant contributor to the lack of operating supplies at the health clinics/posts and municipal hospital level, which in turn has resulted in user fees for PHC services and high out-of-pocket expenses. Thus, there must be emphasis on building accountability into the governance structure at the provincial and municipal levels.

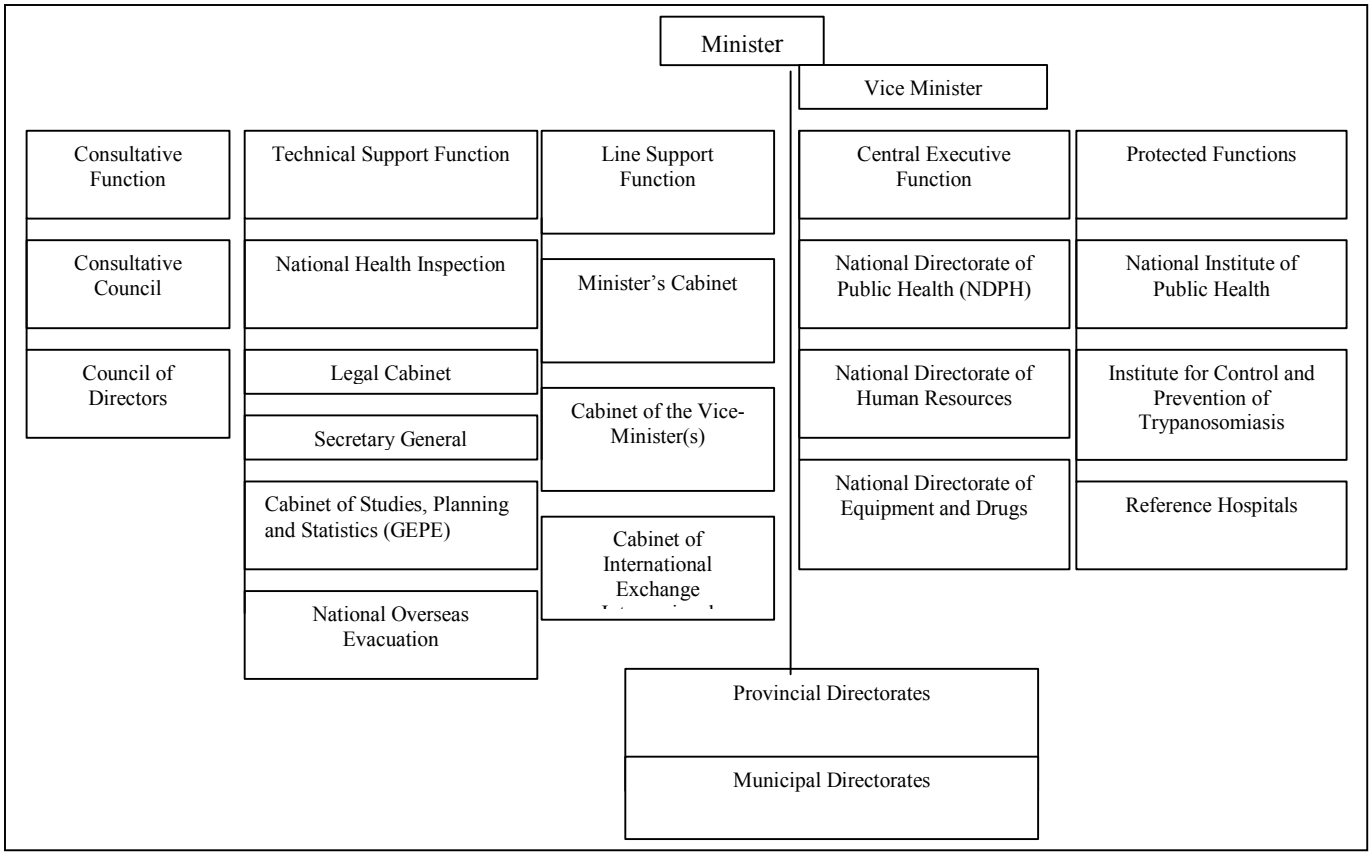
4.3 Human Resources and Health Facilities

4.3.1 Policies, Plans, and Regulations

MOH organizational structure

A 2000 decree organized the MOH into five functions: consultative, technical support, line support, central executive, and protected institutions (see Figure 9). Each function is subdivided into two to five areas (i.e., directorates, cabinets, institutes, or councils), each with its own hierarchy. Despite this theoretically clear hierarchy, boundaries between areas with potentially overlapping roles have not been fully defined , so how each area implements its functions is still fluid. In addition, individual areas may not have the capacity to fully implement their assigned functions.

Figure 9. MOH Organizational Chart



Human resources and facilities

In recent years, the MOH has updated many laws governing human resources and facilities. For instance, executive decree 53/01 defines norms for the number of clinical and non-clinical staff per health center, health post, and hospital according to bed size, and it defines the management structure of a health center. Executive degree 54/03 establishes the organizational structure of the various health units and the minimum package of services they should offer, defines staffing norms for different clinical services, and delineates the role and responsibilities of key managerial, administrative, and supervisory staff. A 2003 decree defines hospital management, outlining staffing, services, minimum equipment, and functional space that each hospital department must have.

There often is a gap between decree and reality, because the current structure does not have the resources to enforce the laws. For instance, health centers and municipal hospitals generally do not conform to regulations on construction, equipment, and organization – a health center may have more beds than a municipal hospital. Recognizing this, Luanda province recently completed an inventory and classification of its health units and proposed new criteria to distinguish between health centers and municipal hospitals. It is not yet clear if the proposed criteria will lead to a reform of current law.

Provincial governments (i.e., DPSs) do not have budgets or staffing to effectively inspect and regulate all health facilities. In Luanda province alone, for instance, 11 inspectors and 34 agents of the Provincial Health Inspection Unit are responsible for the inspection of the 85 public health units,

more than 600 private sector health units, new licenses, and a broad range of commercial establishments serving the Luanda provincial population of 4 to 5 million, such as pharmacies, restaurants, cargo ships delivering food products, and mortuaries. In other provinces, the budgetary and logistical constraints to inspection are likely even greater.

The MOH's current lack of capacity to enforce laws and regulations governing health facilities is due to inadequate budget and manpower, which in turn is partly due to the MOH's limited ability to plan and justify its resource needs (see more in the Health Financing section). A key MOH representative explained that most MOH divisions do not have the competency to project resource "needs of the following year"; in at least one instance when the MOF did not receive this information from the MOH, it used historical information.[5]

4.3.2 Number and Distribution of Health Facilities and Human Resources

Health facilities

As discussed in Section 2, the National Health Service is organized into three levels of care, national/specialized hospitals, provincial hospitals, and primary care facilities, the latter comprising municipal hospitals, health centers and posts. Recently published documents cite different numbers of facilities at each level: 27 (MOH 2001:29) to 100 (MOH Planning and Statistics Office 2003) national and provincial hospitals, 249 (MOH Planning and Statistics Office 2003) to 251 (MOH 2001:29) functional municipal hospitals or health centers, and 725 (MOH 2001:29) to 926 (MOH Planning and Statistics Office 2003) health posts, suggesting some uncertainty in classification or, as is likely the case of health posts, lack of updated information on functionality. Table 3 shows the distribution of the different levels of health facilities by province.

A 2003 decree defines health centers as units serving up to 75,000 inhabitants (equivalent to 0.267 health centers per 20,000 inhabitants). Applying this rule to recent population projections by province (MOH 2001:21), seven out of 16 provinces have a shortage of health centers. Public investment seems to emphasize hospitals over health centers and posts, and this emphasis seems likely to continue – only 7.3 percent of the MOH Program for Public Investments budget for 2005-06 targets PHC infrastructure as opposed to hospitals. The utilization rate has been estimated at 0.34 consultations per 1,000 inhabitants (MOH 2001:30). Effective coverage as estimated by DPT3 immunization rates was estimated at 59 percent in 2004 (WHO 2004).

The private for-profit health sector has mushroomed since its legal inception in 1992. In August 2005, the Luanda Provincial Inspection Unit reported 628 private clinics, representing 88 percent of all Luanda clinics. A MOH document (MOH 2001:30) quotes a poverty study finding that 38 percent of the study sample used public sector providers (compared to 34 percent for private sector, with the remainder using traditional medicine providers or self-medication), though the study sample is not described in the reference. Statistics for Luanda province from 2000 (MOH 2001:30), which has higher access to institutional health services than elsewhere in the country, estimated that only 31 percent of expected number of deliveries took place in the public sector.

[5] For more discussion about this issue at the provincial level, please refer to the provincial government section under 4.2.3.

Table 3. Public Sector Health Units, by Province, Complexity and Functional State, Angola 2002

Province	Hospitals			Health Centers			Health Posts		
	Functional	Not functional	No. per 100,000 inhab.	Functional	Not functional	No. per 20,000 inhab.	Functional	Not functional	No. per 5,000 inhab.
Bengo	5	1	2.3	2	1	0.2	30	57	0.7
Benguela	10	0	0.4	25	0	0.2	65	2	0.1
Bié	4	0	0.4	7	0	0.1	35	0	0.2
Cabinda	4	0	0.9	11	0	0.5	79	26	0.9
Cunene	2	0	0.6	8	0	0.5	52	0	0.8
Huambo	7	1	0.7	36	0	0.7	44	86	0.2
Huíla	6	0	0.4	21	3	0.3	99	166	0.3
K. Kubango	8	3	2.3	4	0	0.2	15	3	0.2
Kwanza Norte	2	0	0.6	12	0	0.7	27	0	0.4
Kwanza Sul	5	4	0.5	18	4	0.4	108	60	0.6
Luanda	13	0	0.3	34	0	0.2	13	0	0.0
Lunda Norte	5	0	0.9	5	10	0.2	12	28	0.1
Lunda Sul	3	0	1.2	3	0	0.2	32	57	0.6
Malange	10	1	2.3	18	2	0.8	50	48	0.6
Moxico	5	1	1.1	14	0	0.6	145	116	1.6
Namibe	2	0	1.1	6	0	0.7	33	0	0.9
Uíge	5	1	0.4	19	8	0.3	55	141	0.2
Zaire	4	0	1.8	6	0	0.6	32	0	0.7
TOTAL	100	12	0.6	249	28	0.3	926	790	0.3

Source: MOH (2003)

Human resources

Currently, 55 percent of the MOH workforce is clinical.[6] Among these are 656 doctors, 16,030 nurses (about three-quarters mid-level and one-quarter with basic training), and 3,670 technicians of various diagnostic and therapeutic functions. WHO data from 1997 show that, compared to other sub-Saharan countries, Angola has about half or fewer physicians, pharmacists, and midwives per capita, and nearly 50 percent more nurses (see Figure 10). (Please note: this information is very dated, but it is the most recent available at this time.)

[6] Direcção Nacional de Recusos Humans, Reconversão de Carreiras—Fase Especial and Regime Geral

Figure 10. Numbers of Public Sector Physicians, Nurses, Midwives, and Pharmacists per Capita in Angola relative to other SSA Countries

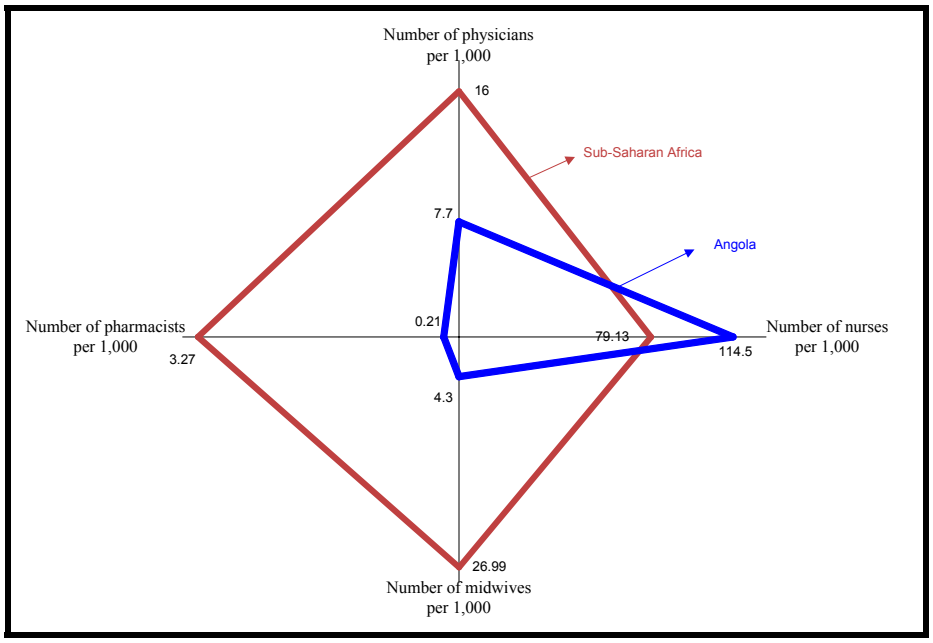


Table 4 shows the uneven distribution of health workers across provinces. Available data from 1998 noted that Luanda has 35 percent of health personnel and 68 percent of foreign and national doctors (MOH 2004a). There are many possible reasons for the poor geographical distribution of health staff. High urban density is a common pattern in many developing countries – in Angola, the war exacerbated this tendency to concentrate near the capital in particular. The poor condition of the health infrastructure in provinces has also been cited as a reason for the poor distribution. In a previous era, health centers and posts were built with adjacent clinician housing, and much of this infrastructure is reported to have been destroyed during the war. Finally, a few people interviewed noted that the MOH sometimes assigns additional health staff to well-staffed urban health units, and provincial health directorates must accommodate them.[7] The rationale for this policy was unclear to those interviewed. According to the provincial inspection unit director, overstaffing in Luanda province is to the point where the provincial government is considering setting up different work shifts to accommodate all health workers. There are anecdotal accounts of health workers opting to take on posts in more remote areas due to MOH incentives, as well as anecdotal accounts of health workers being posted to underserved areas only to quickly arrange for transfer to Luanda.

The current salary structure for nurses and doctors is comparable or superior to corresponding salaries in other divisions in the public sector. There is a perception that health worker salaries are low, in part due to the fact that the current salaries reflect a 2002 salary structure negotiated between the MOH and unions which decreased the number and amount of subsidies. Currently, both nurses and doctors receive a 5 percent "direct exposure" subsidy over their public sector salary schedule. Doctors also receive a 200 percent subsidy for overtime hours up to 24 hours, and nurses have subsidies for evening and shift work hours. The new salary structure also increased the base salary

[7] Interestingly, Executive Decree No. 53/01 specifically conditions the transfer ("movement") of staff to the availability of vacancies (at a health unit).

levels, from which pensions are based. Comparisons with the private sector are difficult due to lack of data. However, according to the director of human resources, a doctor receiving the full subsidy[8] earns a comparable salary to a doctor working for Sonongol, a state oil company. In addition, starting nursing salaries are on par with or superior to starting salaries for other jobs in the public sector requiring the same educational background.

Table 4. Medical and Nursing Staff in the Public System, Angola 2002*

Province	Doctors				Nurses	
	Nationals	Foreigners	Total	No. per 1,000 inhab	Nº	No. per 1,000 inhab
Bengo	11	6	17	0.08	259	1.2
Benguela	29	12	41	0.02	2,012	0.8
Bié	6	0	6	0.01	936	0.9
Cabinda	26	0	26	0.06	739	1.7
Cunene	8	3	11	0.03	326	1.0
Huambo	11	8	19	0.02	908	0.9
Huíla	33	4	37	0.02	1,277	0.8
K. Kubango	2	4	6	0.02	314	0.9
Kwanza Norte	0	5	5	0.02	489	1.5
Kwanza Sul	7	12	19	0.02	497	0.5
Luanda	471	106	577	0.13	4,904	1.1
Lunda Norte	16	8	24	0.04	481	0.9
Lunda Sul	8	5	13	0.05	417	1.6
Malange	5	4	9	0.02	539	1.2
Moxico	2	4	6	0.01	528	1.2
Namibe	11	11	22	0.12	477	2.6
Uíge	4	5	9	0.01	582	0.5
Zaire	2	0	2	0.01	352	1.6
TOTAL	652	197	849	0.05	16,037	1.0

Source: Ministry of Health (2003)

* The John Snow International benchmark for numbers of physicians, nurses, and midwives is of at least 2.5 health staff per 1,000.

[8] The director of the MOH Human Resources Directorate noted that almost all doctors work the full overtime hours due to a shortage of doctors in the country.

4.3.3 Other Aspects of Health Service Delivery

Health facilities and human resources are just inputs into the system, and a "sufficient" number of well-trained health cadre that are rationally distributed according to the health needs of a population working in well-equipped and -functioning health facilities is not sufficient to achieve good health service delivery. Inputs must feed into system processes to generate desired health outcomes. Three processes worth mentioning are health worker training and supervision, the referral system, and structural support for quality assurance.

Health worker training and supervision

The MOH Human Resources Directorate (HRD) recognizes the need to improve the quality (rather than quantity) of health workers. Many basic-level nursing schools in the provinces are overcrowded, use outdated curricula, and are staffed with teachers who lack continual education and are not updated on new norms. Promotion has not been based on clinical competency or performance, as the current evaluation forms are the same as those used for all public sector jobs. In addition, there is a contingency of health workers from UNITA who were folded into the system as part of the peace agreement. The HRD is implementing a plan to reduce the number of health workers, using a strategy that includes reducing administrative staff, admitting fewer students into basic-level nursing training, training basic-level nurses to mid-level, and using provincial nursing schools to provide continuous education (source: HRD strategy as discussed by the director of the HRD).

Currently, in-service training and clinical supervision is conducted vertically by national-level programs under the National Directorate of Public Health (NDPH), many of which have corresponding offices at the provincial level. For example, IMCI[9] has been introduced to the country by training a team of trainers at the central level who are mobilized to the provinces (interview with the Infant and Adolescent Health Section of the Department of Reproductive Health within the NDPH). Anecdotal accounts have noted that nurses who were trained in IMCI by the MOH were found to follow care norms more closely than doctors. Due to budget limitations, however, the capacity for supervision is largely dependant on donor support to programs.

The HRD and several donors agreed that there is a need to decentralize and integrate supervision across programs. The December 2004 version of the 2005-06 MOH budget includes health management training for provincial-level staff at four provinces,[10] the elaboration of an integrated supervision program,[11] and support to provincial/municipal supervision.[12] Luanda province alone has provincial-level coordinating bodies, one for obstetric care and another for pediatric care.

Clinical supervision by the municipality does not currently occur in Angola.[13] Partly due to overlapping mandates by two different government bureaucracies,[14] the person in charge of verifying

[9] IMCI, a WHO child health strategy, includes an integrated case-management component for health care staff.
[10] US$50,000 budgeted for 2005
[11] US$45,000 budgeted for 2005
[12] US$180,000 budgeted for 2005
[13] In fact, the municipal health directorate does not exist in all municipalities.
[14] As show in Table 2, the administrative body at the municipal level is the municipal section. According to a 2/00 MOH decree, the municipal department of health is the entity that orients and coordinates the municipal health section. On the other hand, a 27/00 Ministry of Territorial Administration (MAT) decree defines as responsibilities of the municipal administrator: "orient economic and social development and assure the delivery of care to the community in its respective geographic area."

data collection at the municipal level is likely not a health specialist, and thus might not have the background to provide clinical supervision. This means that, while they may have the function of verifying the data quality of the health units of their municipality, they are unlikely to provide clinical oversight at the municipal level. This is unusual because supervision of clinical data quality and clinical care are two activities that would otherwise have logically and logistically been the domain of the same supervisor.

Referral system

Despite the existence of classification of the three levels of care, the 2005 Annual [Health] Sector Program notes that "there is no referral scheme and clear inter-relation between them."[15] Though the scope of this assessment did not permit more clarity regarding the problems with the referral system, it is particularly problematic in Luanda. According to a director of a national-level hospital, the second level of care "does not exist" in Luanda, though in theory, all three levels exist. In other words, health centers in Luanda refer directly to national level (i.e., tertiary care) hospitals.

Structural support for quality assurance

Quality assurance refers to the systematic process of defining, monitoring, and improving the quality of health services continually within existing resources. As stated in a 1999 decree, NDPH is responsible for developing, disseminating clinical guidelines, and "surveillance" or "supervision" of their implementation. On the other hand, the same decree defines an official role in quality for the General Health Inspection. It is responsible for "stimulating improvement of quality of service delivery to the diverse levels of care (…) via the promotion of implementation of quality assurance norms." However, it does not yet have capacity or expertise to assure clinical quality. In Luanda province, the provincial inspection unit, which would be the operational arm of this inspection function, is focused on licensing facilities, which is basic assessment function of providing quality care.[16]

The clinical care standards have thus far been under the domain of the national-level programs, which have representation at the provincial level. The 2005 Annual Health Sector Program lists 15 functioning vertical programs, 10 of which receive external financing support (e.g., WHO, EU, UNICEF, Rotary). In recent years, many of these programs – in particular those with external support – have updated or developed and initiated the implementation of clinical norms and guidelines (e.g., IMCI, maternal health).

Aside from training and supervision, the limitations of which are discussed above, there appear to be no other system-wide mechanisms for ensuring quality of care. The HIS system currently focuses on surveillance and basic service volume information, so that there are few quality indicators that are tracked, with the exception of externally supported initiatives. One such example is the MSH/Pathfinder maternal and child health reinforcement project, which performs periodic audits in selected health units based on informal accreditation standards successfully applied by the PROQUALI project in northern Brazil.

[15] Programa Annual do Sector, MOH Angola 2005, page 16.
[16] This appears to be another instance in which there is not enough organizational clarity of how functions currently shared by different MOH divisions will be shared in the future.

4.4 The Role of the Private Sector

4.4.1 General Environment

Angola adopted market reforms from 1987-1991 to shift from a socialist to a market economy, but without the regulatory capacity or adequate checks and balances on the concentration of economic power. For example, there has been privatization of state companies through a noncompetitive process to award them to individuals with political connections (Hodges 2004). The general environment for private sector activity is challenging due to poverty,[17] inflation, bureaucracy, lack of credit, and the dominance of state institutions with limited accountability. The cost of doing business is high due to extensive bureaucracy for establishing and operating any business, corruption, and unenforceability of contracts. Lack of competition appears to be increasing the price of imported goods, which increases the cost of doing business in Angola. The IMF has recommended structural measures to improve competition and contract enforcement (IMF 2005).

The Angolan banking system comprises only 11 banks dominated by two publicly owned banks. The banking sector is focused on foreign exchange operations, with limited exposure to the Angolan private sector. Total bank assets, largely in foreign currency, account for 32 percent of GDP, but bank credit to the local economy represents only 5 percent of GDP (IMF 2005). ProCredit Bank, an international financial group dedicated to small and medium enterprises, opened NovoBanco in Angola in 2004 to serve the small and medium enterprise market. NovoBanco Angola was one of the fastest growing banks in ProCredit's history,[18] currently with 7,000 savings accounts and 800 loans with a default rate of less than 1 percent. Borrowers include pharmacies and clinics.

4.4.2 Legal Framework and Regulation

Private provision of health services is legal (Decree 34/92). The law prohibits advertising by private health providers (Decree 48/92, Section 43) but advertising type signage was evident at clinic and hospital locations. Private providers must be licensed (Sections 34–42). Private pharmacies are also legal (Decree 36/92, Sections 1–68). The law regulates the qualifications of all providers (doctors, nurses, pharmacists, allied health personnel) but there is no real enforcement.

The laws for non-profit health organizations (Decree 92, Article 33–34) subject such organizations to orientation and inspection by the MOH, and allow public support, both financial and technical. The latter provides a legal basis for public–private partnership in service delivery (see below). The regulation of international NGOs generally is a "long saga." During the war, the government had some negative experiences with international NGOs 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. The new 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.

[17] Angola's poverty reduction strategy notes that 68 percent of the population lives below the poverty line of $1.70 per day.

[18] The ProCredit Bank group operates 19 financial institutions focused on mirco, small, and medium enterprises in Eastern Europe, Africa, and Latin America.

4.4.3 Private Health Providers

In its Health Sector Development Plan 2000-2005, the MOH clearly incorporates the private sector, for-profit and not-for-profit, as a key component of the Angolan health system (see Figure 1 in Section 1). Like most other African countries, there is evidence that the private health sector plays a significant role in Angola, both in terms of service provision and financing (household out-of-pocket payments and employer-based coverage). According to one household survey[19] (MOP 1995), 41.5 percent of respondents who were ill during the two week recall period sought private health services compared to 36 percent who used public sector services and 24 percent who self-treated. Use of private providers was higher (50 percent) among respondents living above the poverty line, compared to poorer households. Use of traditional healers was minimal (see Table 5).

Table 5. Percentage of Respondents who were Ill during a Two-week Recall Period by Poverty Group and Type of Health Services Sought

	Poverty Groups			
Types of services	**Extreme**	**Moderate**	**Above poverty line**	**Total**
Public services				
Doctor	26.5	28.7	25.5	27.7
Nurse	3.6	8.5	6.4	7.2
Subtotal	30.3	37.2	31.9	34.9
Private services				
Doctor	15.6	14.8	26.0	19.2
Nurse	17.0	20.5	22.4	20.9
Traditional	0.6	1.2	2.0	1.4
Subtotal	33.2	36.5	50.4	41.5
Self-treated	35.9	26.1	17.7	24.0

Source: MOP (1995)

A 2002 survey done of 1,642 households in three municipalities in Luanda province found much lower utilization of private services (11 percent) than of public services (53 percent) and self-treatment (36 percent) (MSH and Consaúde 2002).

National data are lacking regarding the size and composition of the private health sector. Most multinational and large state-owned companies either own and operate health services for their employees, or contract with private providers. There are hundreds of private clinics and retail pharmacies in Luanda alone. A 1999 survey found 425 private health entities of all categories in Luanda province (MOH 2001:21). Most of the for-profit clinics are begun with personal/family finances. Most of the private hospitals are established with either external financing (e.g., religious organizations), or by a large employer (state-owned company), or with state financing and then later privatized (e.g., the state-of-the-art Multiperfil facility).

[19] Due to ongoing civil war, the survey included 5,783 households in only five provinces (Luanda, Moxico, Cabinda, Benguela, and Huila).

Private providers are not well organized. Since 2001, there is an association of doctors, the *Ordem dos Medicos de Angola*, for which membership is required by law. Currently, the organization reports having 1,657 doctors registered (1,487 Angolan nationals and 170 foreign doctors), of which 1,342 (81 percent) are registered in Luanda. Note that this number is well above the number of doctors (656) reported by the MOH as employed in the public sector. No other category of health worker has an active professional association, nor do private clinics or hospitals.

Not-for-profit sector

The not-for-profit sector comprises international and Angolan NGOs (including civil society organizations), and religious organizations. This sector is involved in a wide rage of health sector activities and in some locations is considered the primary source of health interventions for the population.

There are about 100 registered international NGOs. The international NGO community is transitioning from emergency humanitarian relief to development assistance.

There are more than 200 registered Angolan NGOs. Strengths of Angolan NGOs include their credibility with the community and reach, and their technical expertise related to their organizational mandate. Weaknesses of the Angolan NGOs are their lack of administrative, organizational/institutional capacity to write proposals, prepare budgets, manage funds, account for how funds are spent, or document well their activities. This weakness makes it difficult for them to receive grants directly from international donors like USAID because they cannot comply with the application and reporting requirements. As a result, funds flow through international NGOs like Population Services International (PSI) and CARE. According to some interviewed, local NGOs are more responsive/dedicated than some of the national NGOs, and training in administrative skills has not been successful due to staff turnover and lack of interest/absorptive capacity. Successful capacity building requires close working relationship and follow-up (*acompanhamento*). The challenge is to work closely the NGO while ensuring its independence.

There are two NGO networks: Network of International NGOs in Angola (CONGA) for international NGOs and Network of National NGOs in Angola (FONGA). CONGA arose in the early 1990s as a liaison group for day-to-day coordination. Membership is voluntary. Members meet regularly and share information through email (no website). FONGA is not as active. The official government agency responsible for NGO coordination, as well as donor coordination, is the previously described Technical Unit for Assistance Coordination. UTCAH maintains a database of all NGOs, produces reports on humanitarian NGO and government activities, and hosts high-level meetings every three3 months. There is a CORE (Child Survival Cooperation and Resource) Group of NGOs and donors that works on specific issues like polio or HIV/AIDS.

In the provinces, government-led coordination of NGO activities depends highly on the motivation and capacity of the DPS officials. NGO representatives reported that provincial-level coordination works well in Huambo (weekly meetings chaired by DPS on health, nutrition, and security), Bie (weekly subgroup meetings on health and nutrition chaired by the DPS director), Benguela, and Luanda. Coordination in other provinces is reportedly inconsistent or non-existent.

Large employers

Formal sector employment is estimated to be less than 50 percent, dominated by the government, state-owned companies, and private companies. Large employers include international corporations

like Esso-Angola, British Petroleum (BP), Chevron-Texaco, Coca-Cola, Oderbrecht, as well as the state companies like Sonogal (oil) and Endiama (diamonds). All large companies provide some health service coverage for their employees. The covered population may also extend to employees' dependents and even employees of subcontractors. Health service coverage is through onsite clinics, company-owned health facilities, or contracts with an independent health facility. For example, Chevron-Texaco provides health services for a total of 4,500 people in the Cabinda province through seven onsite doctors and a contract with Medigroup Clinic. The company also supports the MOH's community health programs. There is no private health insurance yet in Angola.

4.4.4 Public–Private Partnership

In addition to private provision of health services, the private sector may partner with the government and/or donors to achieve public sector goals. USAID/Angola is one of the most successful implementers of USAID's Global Development Alliances wherein private partner involvement and funding are an explicit part of mission programming. For example, USAID will partner with Esso in the health sector, and with BP to extend access to electricity to improve domestic economic growth and delivery of essential services.

Other examples of public–private partnerships include the "JUCA" educational campaign against malaria (MOH with Sonogal, Esso, BP, and other companies), which provides educational brochures, radio and TV spots, and a video for schools and communities. The International Finance Corporation helped Odebrecht of Brazil (construction company) structure a comprehensive HIV/AIDS program in Angola that includes outreach, counseling, testing and treatment for employees and communities in which company operates, and reaches about 100,000 people. There are several examples of successful partnership between the MOH and Catholic entities to operate hospitals. The Catholic entity manages the hospital and provides supplies, equipment, and maintenance. The hospital staff (doctors, nurses, technicians) are public sector employees paid by the government. Quality is reportedly high and user fees lower than found in purely public hospitals. The group mentioned a hospital in Cubal (Benguela Province), Divina Providencia Hospital in Luanda city, the Italian Catholic Hospital in Kilamba Kiaxi (Luanda province), and Seles Hospital in Cuanza Sul province. There is interest in identifying ways to replicate this type of partnership.

Some interviewed voiced concern about the lack of coordination of private companies' forays into public health activities, for example, inconsistent messages or information disseminated to populations regarding prevention of HIV.

The World Bank study in 2003 on corporate social responsibility called for a more strategic approach in Angola wherein "…all partners act upon their core competencies - their complementary resources, knowledge and skills - to jointly address the complexities surrounding social development. This is very different from traditional, charitable approaches to corporate social responsibility, where companies might be expected to contribute little more than cash. Core competencies might include the **private sector's** financing, project and financial management, IT and engineering skills; the **public sector's** strategic co-ordination or ability to source funding, and oversight; **NGOs'** ability to identify social and environmental issues of concern and to mobilize local community participation to help address them" (Blakeley 2003).

4.5 Pharmaceutical Sector

4.5.1 Overview

Pharmaceutical products enter the Angola health system in one of three ways:

1. Essential drug program from MOH
2. Non-essential drugs procured individually by national and provincial hospitals
3. Private sector (private clinics, private pharmacies, informal markets, etc)

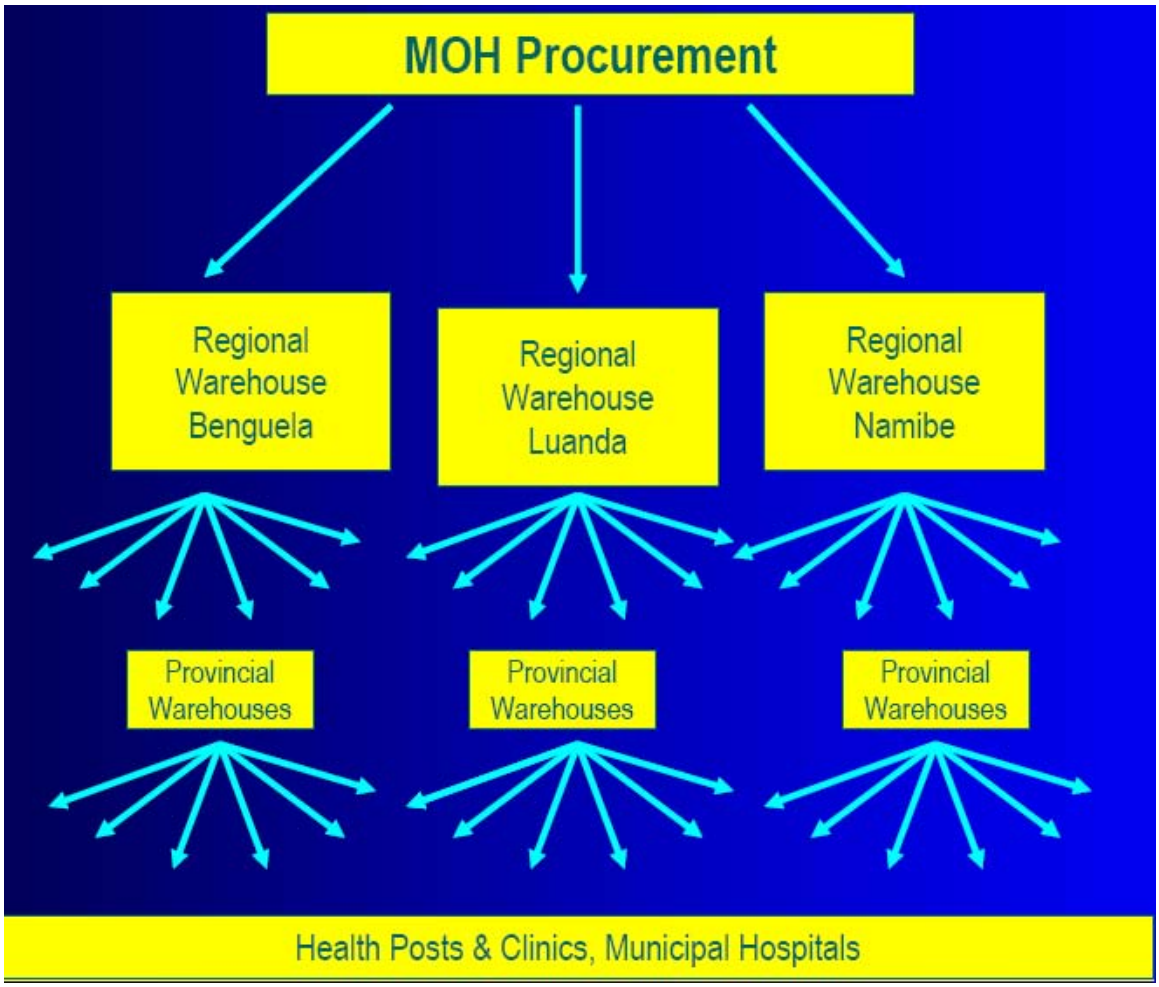
It is loosely estimated by the National Essential Drugs Program (NEDP) that 70 percent of drugs are bought informally and 35 percent of all informal drugs are counterfeit. Beyond that, however, very little is known about the private and informal system. The scope of this analysis will be limited to the public sector.

The functioning of the public drug management system has suffered from the lack of a national pharmaceutical policy. Thus, at the moment, there are no functioning quality assurance mechanisms, national formularies, drug registration policies, or any overarching regulatory framework. That said, Angola, with the help of the EU, is in the process of writing a comprehensive national drug policy. While an early draft of the policy exists, many details are still unclear, as are their political feasibility. Therefore, this analysis will focus on the current state of affairs.

4.5.2 Drug Procurement at the PHC Level: The National Essential Drug Program

The NEDP is a MOH program that exists to provide the pharmaceutical inputs for national health priorities. These priorities include (1) immunization, (2) HIV/AIDS, (3) malaria, (4) TB, and (5) polio. Since the priority areas are primarily delivered by health posts, health centers, and municipal hospitals, the NEDP channels the drugs exclusively to those levels. In 2005, the MOH budgeted $7.3 million (one-third of its total budget) to procure essential drugs (MOH 2005). Figure 11 describes the flow of drugs through each level.

Figure 11. The NEDP Procurement and Distribution System



Selection

Drugs are selected for the NEDP based on the criteria set by the WHO essential medicines guidelines. These guidelines are adapted by the MOH and partners (such as the EU in 2004 and 2005) for the Angolan context, taking into account national public health priorities. Drugs are selected for three different drug kits by health facility level: health post kits (currently containing 42 drugs), health clinic kits (currently containing 45 drugs), and complementary kits for municipal hospitals that staff physicians (currently containing 40 drugs). Over the last five years the composition of drugs for each type of kit has been different with each procurement, while the number of drugs has always remained between 40 and 50. The latest kit composition can be found in Annex I. Complementary kits, while existing on paper, have yet to be regularly procured by the MOH.

The number of kits purchased is based on two factors: available funds and the expected number of future consultations at each relevant health facility. The level of funds for the NEDP is determined by the MOH.

The expected number of future consultations is, in principle, determined by analysis of past utilization information. Utilization information at the post, clinic, and municipal hospital level is aggregated by each DPS, and forwarded to the MOH. The MOH then analyzes this information to plan the number of kits to be procured.

Health posts, health centers, and municipal hospitals that staff physicians are allocated one kit for every 1,000 consultations. According to the EU, this policy has resulted in stock problems, as clinics with 1,800 consultations would only receive one kit. This has also created the incentives for clinics to overstate their needs, though we have not verified whether facilities are acting on this incentive. Additionally, municipal hospitals that staff doctors are allocated one complementary kit for every 500 consultations. But, as stated earlier, these kits have not yet been regularly procured by the MOH.

According to the MOH, the planning process at the MOH level is not functioning optimally. Most of our interviewees agreed that the information was flowing regularly (though of uncertain quality) from the DPS to the MOH. However, the ability of the MOH to analyze this data for procurement planning is limited. The EU has placed technical assistance within the MOH Planning Department to assist in data analysis.

Procurement

It is worth noting a strength of the procurement system. The procurement procedure under the NEDP is clear, reflects modern competitive practice, and MOH staff know how to follow the procedure. In principle, drugs are purchased via competitive tender on a yearly basis.

In practice, the MOH has not completed a regular, non-emergency drug procurement in nearly two years.[20] Instead, most procurement is done by donors, such as the EU and UNICEF. Some donors expressed concern that the MOH is pursuing a strategy of relying on donors to conduct annual procurements, leaving the MOH to conduct only emergency procurements. The instability resulting from the lack of a standard procurement cycle has, at the time of this report, left 13 out of 18 provinces in Angola facing severe stock-outs. At the present time, the MOH is in talks with the International Development Association (IDA) to fly in 1,800 kits at a cost that is nearly double the cost of a regular, shipped procurement.

All drugs are listed in using their international non-proprietary names. Typically, Mission Pharma and the IDA are the two main suppliers. When drugs are purchased at their regular time via competitive tender (as was the case in 2002), they are typically purchased at a unit cost that is consistent with international prices, according to the EU.

Procurements, when conducted by the MOH, have historically taken longer than the 3–4 month average reported by IDA. For example, a procurement with IDA that had begun in July 2004 (valued at $7 million) was reportedly completed August 2005, with the first kits scheduled to arrive in October 2005 due to delays in finalizing a contract. According to the latest tender documents, the Angolan government has adopted the practice of tax-exempting pharmaceutical products related to the priority areas of malaria, HIV/AIDS, and TB.

[20] The team was not able to get information on the performance of NEDP procurements prior to 2002.

Distribution and logistics

The most recent tender documents call for "delivery duty paid" procurement, such that the seller is responsible to bring the drugs from the manufacturing plant to the main warehouses of Angola. The seller is responsible for paying port clearance, which can be as high as 15–20 percent of the value of the product, depending on the clearing agent.

Angola has three major regional warehouses, located in Benguela, Luanda, and Namibe. Drugs are to arrive directly to these warehouses twice per year. Each warehouse has an employee who is responsible for arranging the transport of drugs to each province. This employee receives his terms of reference from the MOH, but is selected at the provincial level. Since all planning is done by the MOH, the warehouse employee is only responsible for ensuring that the said amount of kits arrive to their respective provinces. This individual is not responsible for any planning.

Once the drugs arrive at the three regional warehouses, they are transported on a monthly basis to each of the 18 provinces. Both rented and government-owned trucks are used to transport the drugs from the three regional warehouses to the provincial warehouses. From here, more trucks are hired to deliver drugs directly to the health posts, health clinics, and municipal hospitals.

In principle, the costs and logistics of all drug distribution, from the regional to the health clinic level, is the responsibility of the MOH. Our interviews have revealed that the lack of resources from the MOH has forced provincial governments to pay for and manage the distribution to the facilities.

In the past, two of the three regional warehouses (Luanda and Bengala) were owned and managed by a public corporation called Anglomedico. This corporation has recently dissolved, and, at the time of this writing, it remains unclear where newly procured drugs will be stored for these regional levels. There are ongoing discussions at the MOH level to purchase and manage their own warehouses, with the support of UNICEF.

In general, warehouse security has been seen as a serious issue inhibiting the functioning of the distribution system. While there is little published data, our interviews with key interviewees reveal that theft from regional warehouses has been an issue. Over the past year, the Benguela warehouse has reported 100 kits missing, and Naimibe has reported 500 kits missing. Further, our interviews with the health post and clinic levels reveal that kit boxes, when they do arrive, have often been tampered with and are incomplete.[21]

Rational use

The MOH has developed guidelines for the use of essential drugs. These guidelines are implemented by offering nurse training at the PHC levels. Nurses, who prescribe 80-90 percent of all essential drugs in Angola, reportedly are more compliant with rational use guidelines than have physicians, according to the NEDP.

The face-to-face rational use training offered by the NEDP is meant to last one week. Our interviews with posts and clinics reveal that face-to-face training is often times substituted by the distribution of pamphlets on rational drug use. These pamphlets are often distributed with the drug kits, and are produced by MissionPharma or the IDA. Some clinics that we visited in Huambo province have organized learning groups, supervised by the clinic manager, in which nurses assign

[21] The team could not locate quantitative data on the number of tampered or incomplete kits.

each other pamphlet readings and discuss the guidelines on a bi-weekly basis. However, it is unknown whether this type of initiative is typical in health clinics across Angola.

User fees

According to MOH policy, all drugs provided by the essential drug kits are to be dispensed free of charge. Thus patients should not have to pay for the key drugs supporting the national health priorities. In Huambo province, our interviews with patients, nurses, and administrators reveal that this policy is typically honored. However, due to the frequency of stock-outs of drugs and supplies, patients commonly go to local markets (formal and informal) to buy these items. In other provinces, user fees (either formal or informal) for essential drugs are charged. We do not know how the prices compare to the private and/or informal sectors.

4.5.3 Drug Procurement at the Hospital Level

All national and provincial hospitals have budget authority, and thus procure their own non-essential drugs. Municipal hospitals also stock non-essential drugs, but must rely on provincial governments for procurement if granted permission for their drug request. We were unable to find any published information on total public spending on non-essential drugs.

At the time of writing, there was no national drug law, and thus no consistent process by which hospitals or provincial governments have managed their procurement. That said, there are many commonalities among the purchasing patterns of these three entities. This section will attempt to describe their drug management cycle.

Selection, distribution, and logistics

Currently, there are no hospital formularies in Angola. Thus, the selection process is not based on policy. While each hospital is different, it appears that procurements are not conducted at regular intervals, but instead, are conducted when the need for the drug arises. Based on our interviews, most hospitals do not have a designated procurement specialist, but rather share this task among physicians or add it to the scope of work of support staff. Usually, approval by the hospital director must be given before any procurement can take place.

There is no policy guidance as to whether the drugs purchased should be generic or branded. It has anecdotally been observed that hospitals tend to favor branded products. There is no study that has compared the prices of the products purchased by the hospitals with any other market prices. According to the hospital directors of several large national hospitals in Huambo and Luanda province, the skew towards branded products is the result of a lack of any quality assurance mechanism. They claim that in the absence of a quality assurance mechanism, they can be more confident that branded products will be of higher quality than generics. Several key government officials also attribute this problem to the lack of education by purchasers about the efficacy of branded products versus generic products.

Our interviews suggest that most often, the drugs are not purchased via competitive tender. The mechanism by which suppliers are chosen is not clear; however, it appears that there are at least three major suppliers. According to two key sources, purchasing agents are given “commissions” by suppliers if they are selected. Therefore, it is likely that firms are not competing on the unit price of the drug, but rather on the amount of commission they offer the purchasing agent. This offers

plausible explanation as to why hospitals, given their limited budgets, are often indifferent to the quantity and price of drugs they purchase.

Drugs are typically delivered directly to hospital warehouses. Delivery charges are typically included in the price of the consignment.

Rational use

The issue of whether hospitals are prescribing drugs rationally is unclear, since most hospitals lack treatment guidelines. There is also a lack of data regarding prescription patterns of physicians. Thus, it is difficult to make a data-based assessment of whether or not physicians are prescribing rationally. That said, key interviewees in the MOH have expressed concern about the over-prescription of antibiotics, prescription of branded products when generic equivalents are available, and over-use of injectables. These arguments have partially fuelled support for the proposed national drug policy, which would impose treatment guidelines.

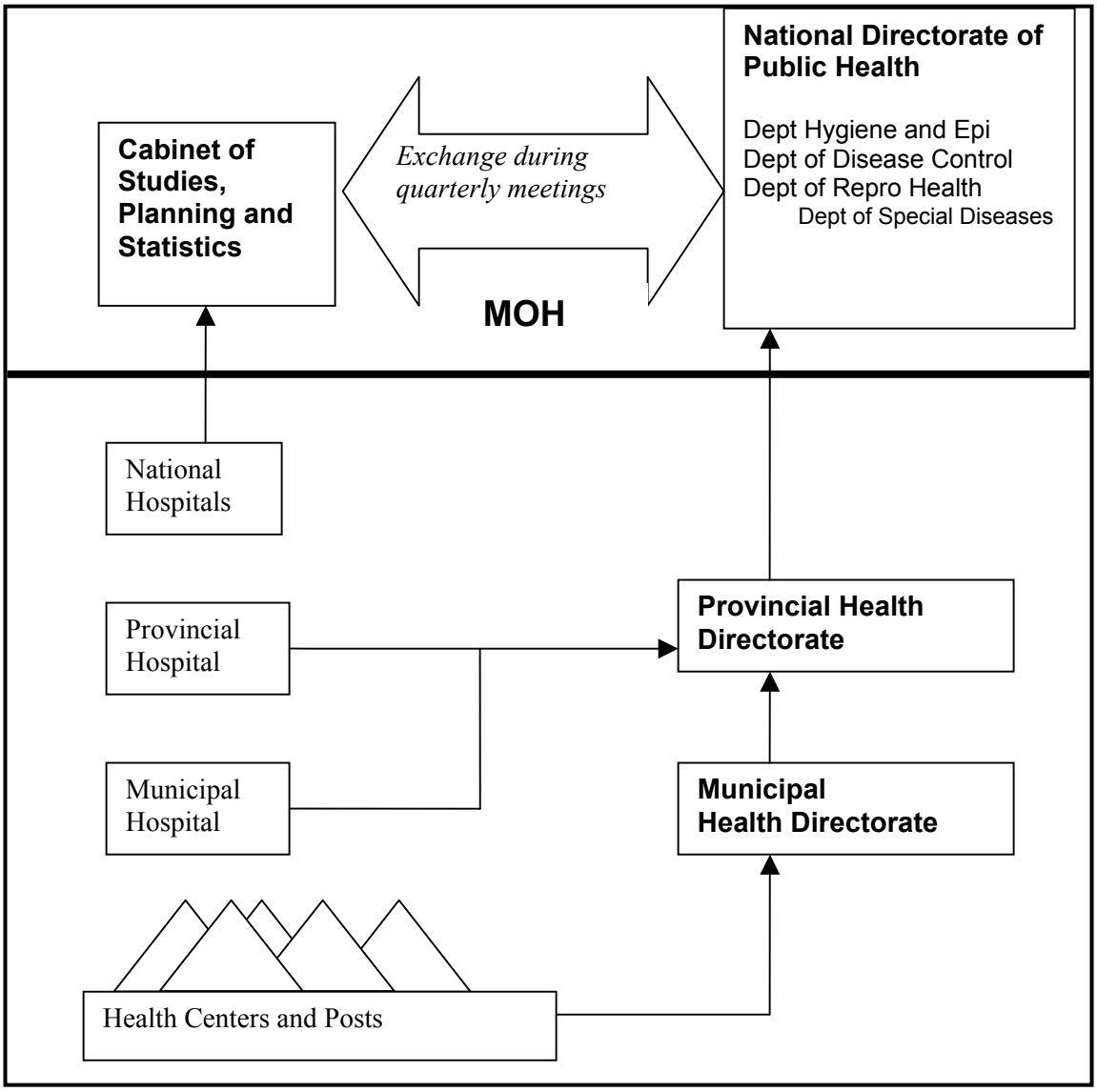
User fees

Hospitals are free to set their own user-fee policies; thus, the prices of drugs vary from hospital to hospital. For example, the national hospital in Huambo has a policy of not charging user fees for drugs. Hospitals in Luanda, however, all charge fees for drugs. Though we have not verified this through a data-based analysis, interviews with MOH officials suggest that a different user fee will be charged for the same drug, depending on the hospital at which it is purchased. It is unclear how these prices compare to the private pharmacies attached to most hospitals, or to the other formal and informal channels.

4.6 Health Information Systems

The routine health information data flows though a paper-based system from hospitals and primary health care units through the DPS and then to the corresponding program under the National Directorate of Public Health (see schematic representation in Figure 12). Where in operation, the municipal health section participates in the information flow; otherwise this level is bypassed. Routine health information data is sent up the notification system monthly to produce a monthly bulletin, while suspected cases of polio, measles, neonatal tetanus, meningitis and malaria are actively collected weekly through the "Rapid Alert System" (*Sistema de Alerta Rápida*). Surveillance data is aggregated and then 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 municipalities through the alert system. Routine epidemiological surveillance data is aggregated at each level of the health system, so that MOH programs have information across provinces.

Figure 12. General Schema of MOH Health Information System Flow



In essence, each program under the NDPH has at least one set of data and forms that is sent up vertically under this system; data collection forms used within each program area were developed at different times by different groups. Every quarter, all the programs as well as other MOH institutes meet to share and reconcile data with each other and with the Cabinet of Studies, Planning and Statistics. 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 quarterly data reconciliation meeting, GEPE compiles the health data that MOH collects into a quarterly and an annual publication. These two publications are disseminated throughout MOH and also back to provincial health directorates.

4.6.1 Health Information Resources, Policies, and Regulations

Within the MOH, HIS functions are shared by several government entities. In addition to GEPE, each program under NDPH (nutrition, women's health, infant and adolescent health, immunization, transmissible diseases, epidemiology, health coverage, etc.) processes its own data. The directorate intends to centralize the data processing function under GEPE. Finally, there are other organs that may collect other non-routine data. For instance, the National Institute for the Fight Against AIDS collects HIV data from sentinel surveillance and VCT (voluntary counseling and testing) sites. However, in theory, HIV cases identified through sentinel surveillance would also be reported through the routine information system.

Budgeting is limited, though the 2005 global MOH budget does include line items for the "revitalization of the HIS" (also described as epidemiological surveillance) under the budget sections for hospital assistance, public health, nutrition, leprosy, vaccination, and EPI. The total budget for the 2005-06 sector program was US$1.5 million. Most of the sources of funds under the surveillance function are external. Since different programs have different levels of support from external partners, the results are noticeable. For certain programs, such as epidemiological surveillance, the role of each level is well defined and structured, and at least in Luanda province there are monthly meetings of municipal-level data collectors. Other programs receiving less support may not have the same level of process clarity.

4.6.2 Data Availability and Quality

Data that is processed through the routine health information system includes data from the following areas: epidemiological surveillance (26 diseases), "hospital" data,[22] nutrition, diarrhea, child health (IMCI), 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, additional reporting requirements may also occur when individual programs receive funding through external partners and must comply with their reporting requirements as well, as occurs in the case of nutrition.

The completeness and accuracy of data collected from registers varies according to the program. For instance, the WHO-supported epidemiological surveillance program provides manpower and vehicles for verification of data quality. Throughout the month, the vehicles circulate throughout Luanda province so that provincial and municipal 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,[23] as well as from other MOH departments, such as the National Blood Centre. Programs with fewer resources are not able to provide the same level of data quality oversight.

[22] Health centers also report on this information, which includes inpatient data (admittances, transfers, deaths, deaths occurring within 48 hours, etc).
[23] The private sector is supposed to report into the HIS, though not all private clinics do.

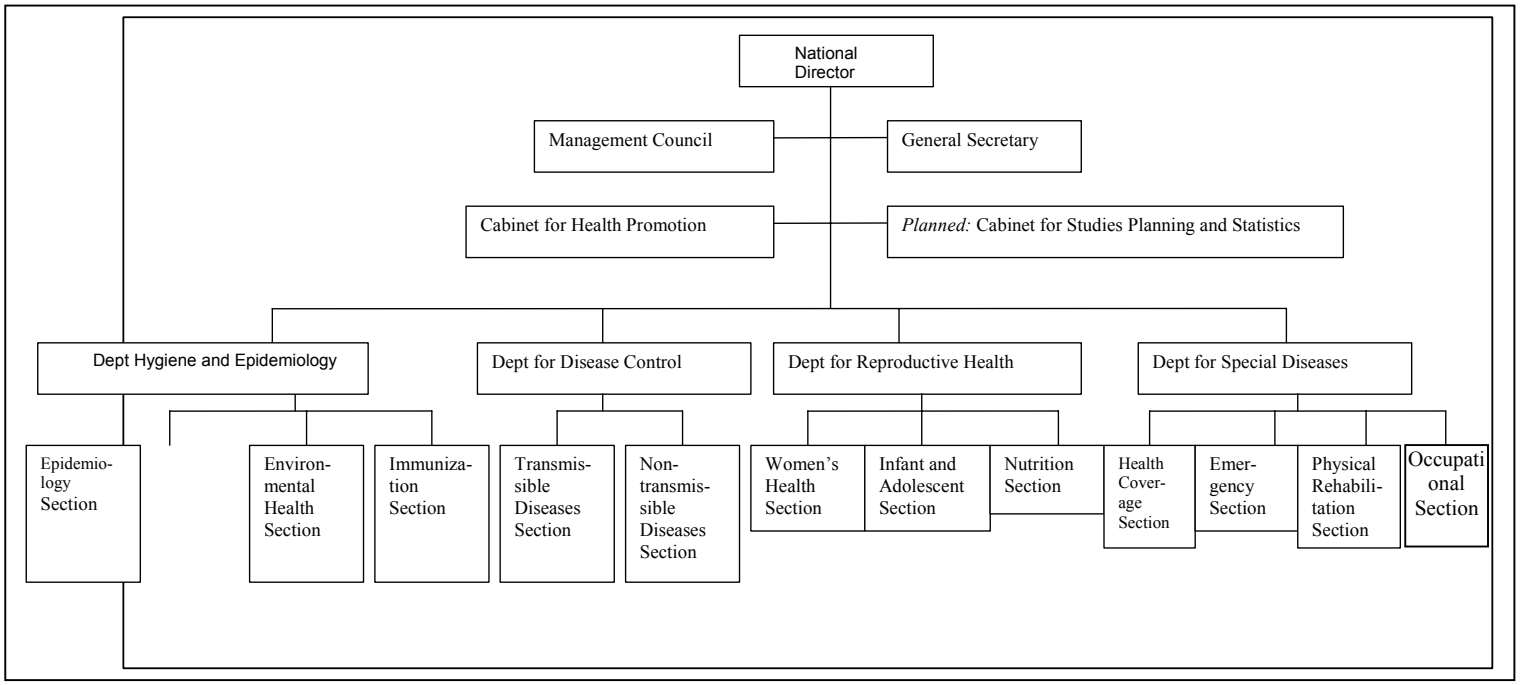
Population-based health indicators[24] are based on projections made from the last official population census in 1970, when the Angolan population numbered 5.6 million. Current population estimates vary between 12 and 17 million people for the country as a whole, and between 4 and 5 million for Luanda province.

In short, data quality is uneven, especially under programs and in geographical locations where data quality is checked infrequently, due to logistical and budgetary constraints. Nevertheless, individual MOH program managers interviewed were aware of the limitations of their information systems and were making efforts to obtain timely data.

4.6.3 Data Analysis

MOH programs under the NDPH generally have the capacity for manipulating data. For example, there are six technical staff in the Infant and Adolescent Health Section (see Figure 13), three of whom are computer literate. The director herself may be the person who will enter, aggregate and graph IMCI data in Excel.

Figure 13. Organizational Chart for National Directorate of Public Health, Ministry of Health



One national program manager stated that capacity for data analysis at the provincial level is weak. Luanda may be an exception. During a monthly municipal epidemiological surveillance meeting in Luanda, data graphed by WHO staff was shared among the group, and the provincial

[24] Population-based indicators are health indicators in which the denominator refers to the population or subpopulation of a geographical area. For instance, HIV prevalence among adults, the maternal mortality rate, and the infant mortality rate are all population-based indicators that are crucial for planning purposes. To obtain reasonable estimates of these indicators, one would need to know how many adults, women who have given birth, or infants there are in a country in a given year.

director for epidemiological surveillance led a discussion that reinforced issues such as timeliness and completeness of data sent from individual health units. Individual municipalities, however, are likely not to have computers and might graph their own data by hand. The capacity to do so varies among municipalities.

At the PHC level, data analysis capacity is reported to be weak. At individual health centers, it is more often the case that forms are filled out (or even collected during 'supervision' visits) and no systematic feedback is ever given. Of course, the data gathered does not allow for measurement of delivery of interventions proven to decrease mortality or improve health. At any rate, at the PHC level, there is already more data collected than the existing HIS has the capacity to analyze.

4.6.4 Use of Information for Management

National-level MOH program managers are the main consumers of the data collected throughout the health system. One key person interviewed suggested that the MOH does not have great budgetary capacity to respond to information, so that in the past, rapid response to epidemics has involved NGOs or other donors. However, Luanda municipality statistical staff reported that surveillance data have elicited provincial-level response in the past. For example, more than one Luanda municipality noted that surveillance data indicating an increase in the incidence of malaria cases has resulted in the distribution of mosquito nets by the provincial government.

More broadly, there clearly are gaps among the information, planning, and budgeting processes. The HIS does provide information that could inform MOH planning and budgeting, though it is unclear to what extent this is done. Existing data may highlight inconsistency in allocation of resources. For example, the team saw charts of MOH budget allocation decisions between two health units that were grossly out of line with data on the respective health units' expenses and patient volumes for the previous year, indicating misallocation of funds. The EU is working at both national and provincial levels to support more rational planning and budgeting practices (see Health Financing section).

4.7 Summary of Findings

This section summarizes the team's major findings for Angola's health system performance against the indicators of equity, access, efficiency, quality, and sustainability (see Table 6, at the end of this chapter). Several issues emerge as priorities that are consistent with the team's technical analysis and USAID/Angola's strategic focus on provision of essential services in the short term (strategic objective [SO]3), and governance in the long term (SO1). These issues are listed below using the "SWOT" framework.

4.7.1 Strengths

- **Quantity of nurses.** Significantly higher number of nurses (114.5/1,000) than in other SSA countries.
- **Training.** MOH/EU plan to focus on increasing the capacity of the existing staff.
- Recognition of need to elaborate/updating legal, administrative, and clinical norms and guidelines, followed by action. The MOH has produced various legal documents that have

been formulated in the last five years.

- **Implementation of some norms/guidelines.** IMCI and MCH protocols have been implemented and health tools, materials, structures, programs have been developed and are functioning.
- **Public-private partnerships.** Successful experiments with public-private partnerships.
- **User fees**, when standardized and with implementation of better exemption practices, allow health facilities to purchase much needed inputs (drugs, supplies, fuel).
- **Health workers and MOH staff demonstrate dedication.** MOH staff interviewed in Luanda articulate the technically right things to do, want to do them, and take action within their sphere of influence. But they accept the fact that higher-level priorities and decisions will limit their resources and actions, and do the best they can within the reality.
- **Less ethnic/religious animosity and lower language barriers** than many SSA countries.

4.7.2 Weaknesses

- There is a **lack of human and institutional capacity** at all levels of the public health system. MOH training is not fully funded. There are other external efforts directed toward training, such as the EU program, but few address the **lack of supervision** once the trained employee is back on the job and none addresses the **lack of inputs necessary for service delivery**. For example, supplies, drugs, basic instruments/equipment, and even electricity and potable water are often missing, so nurses and doctors cannot apply what they have learned. In terms of managerial capacity, again basic office supplies, equipment, and funds for transport to exercise supervision are missing, so provincial or municipal staff are not able to apply what they have learned.
- Clearly, a major source of the deficiencies cited above is insufficient public health financing, especially for provincial and municipal health directorates, and PHC services. The underlying cause of the **misallocation of resources** is **political will,** which must be addressed over the long term.
- **Misallocation of staff** with excessive levels in Luanda, Huambo, and other cities and severe shortages in other locations.
- Due to the under-funding of municipal hospitals and health centers and posts, **user fees** are recognized by the MOH as a significant barrier to access. Some people interviewed have noted declining utilization of PHC services, but trend data on utilization was not available to confirm this.

4.7.3 Opportunities

- Post-war **transition period**. Angolans are open to change and eager for improvement. There is some level of optimism because peace alone is reason for optimism. This energy can and should be harnessed. NovoBanco's experience (extremely low default rates) and the huge numbers of people who apply for few job openings (e.g., 300 who applied for 10 vacancies

for filing medical records at Luanda DPS) show that, despite governmental barriers to business, people *want* to work and will work *hard*. This might mean in particular that recommendations to USAID in health should seek as much as possible to integrate with programs that have a more direct benefit to economic activity and civil society.

- Angola has a **young population –** 60 percent of Angolans are under the age of 18. This means a shorter memory of the war period, and a new generation that can build the much-needed civil society to create demand for better quality services.
- **Elections in 2006** could push decision makers at all levels to prioritize social services and make more pro-poor investments.
- Angola's **long-term economic outlook** is very positive. Already there is a relatively low level of donor support to the health sector, unlike other developing countries with similar health system weaknesses, combined with greater dependency on external funding. Both are opportunities for long-term sustainability of improvements achieved in essential services and strengthened institutional capacity.
- **Other donor investments** in health system strengthening that are in progress or planned (EU, UNDP/Global Fund, World Bank) with similar goals and strategies. Need coordination to maximize impact of everyone's investment.

4.7.4 Threats

- **Elections in 2006** could generate a flurry of facility construction that is not part of a rational plan based on need (poorly located), nor part of the health budget for recurrent costs (staff and supplies).
- The **country's cost structure** is exceptionally high, discounting the impact of everyone's efforts including the government. Mitigating this threat requires interventions to increase economic growth and competition.
- Growing **external assistance** from China that so far has not coordinated with other donors to ensure a consistent message that emphasizes equity and long-term development. Chinese assistance appears to be focused on construction and, like "election spending," could lead to health facilities that are not part of a rational plan.
- There is anthropological evidence that people living with poverty and war necessarily have a very **short-term perspective** focused on survival. This can be a major obstacle to changing behaviors like those related to successful HIV prevention and family planning.

Table 6. Summary of Angola Health System Assessment Findings

<table>
<tr><th rowspan="2">Health Subsectors</th><th colspan="5">Health System Performance Indicators</th></tr>
<tr><th>Equity</th><th>Access</th><th>Efficiency</th><th>Quality</th><th>Sustainability</th></tr>
<tr><td>Governance</td><td colspan="5">Power is concentrated in the executive branch and is very top-down, despite decentralization. The legal framework governing the health sector is relatively detailed and clear. Regulations are in place, but enforcement is weak. The MOH articulates sector plans that would address priority services and improve health system performance across all 5 indicators, but implementation is incomplete. Decisions about resource allocation and implementation are inconsistent with stated plans and priorities. There is little experience or mechanisms for accountability. Some provinces and municipalities working closely with private non-profit organizations on health issues.</td></tr>
<tr><td>Financing</td><td>Pattern of regressive allocation of public assets and resources to an elite minority, at the expense of larger population.</td><td>Due to inadequate funding of PHC, health centers and posts charge user fees that are a financial barrier to access.</td><td rowspan="2">40% of public health financing allocated to tertiary care; only 27% to primary and secondary care

Misallocation of resources (funds, drugs, human resources, facilities) away from highest burdens of disease.</td><td rowspan="3">Norms, protocols and training efforts are in progress.

However, lack of supplies, drugs and supervision at PHC level severely weakens quality of service delivery.</td><td rowspan="2">External health financing is lower (8%) than other SSA countries (20%). Due to mineral wealth, Angola theoretically has the resources to sustain its health system, and even increase health financing.</td></tr>
<tr><td>Human Resources/ Facilities</td><td rowspan="2">Staff, facilities, and drugs concentrated in hospital care, not PHC that would most benefit the 60% of the population below the poverty line.</td><td>Estimated 60% of population is without physical access to any public facilities.</td></tr>
<tr><td>Drugs</td><td>Severe stock-outs of essential drugs</td><td>Leakage of essential drugs into informal market.</td><td>Essential drug procurement dependent on donors.</td></tr>
<tr><td>HIS</td><td colspan="2">Health information is incorporated into MOH plans but since the plans are not fully funded and implemented, the HIS does not effectively promote equity and access</td><td>Parallel information flows.

Information not used at lower levels.</td><td>HIS not yet used for quality assurance.

Data quality is unknown. Lack of forms, calculators, supervision at lower levels.</td><td>HIS that are not used by the staff who collect and aggregate the data are usually not sustainable.</td></tr>
<tr><td>Private Sector</td><td colspan="3">Large employers, NGOs, and religious groups are filling an important gap in service delivery contributing to equity, access and efficiency.</td><td>No data</td><td>Very likely sustainable with continued economic growth.</td></tr>
</table>

5. Recommendations

The team is tasked with identifying the health system activities for USAID that fit with the Mission's Fragile States strategy[25] for an integrated program that will increase essential services in the short term and improve governance in the long term. USAID/Angola's proposed Strategic Objectives are:

- SO1 Inclusive Governance Reform Advanced
- SO2 Basic Economic Opportunity and Livelihoods Maintained/Restored
- SO3 Increased Access to Essential Services by Local and National Institutions; with a focus on HIV/AIDS, malaria, and family planning.

In addition, the strategy calls for integration across all levels (national, provincial, municipal, community) with gender as a cross-cutting theme, and a geographic focus in selected provinces. The health sector program will have depth in malaria (Presidential Initiative), HIV/AIDS, and family planning.

This health system assessment identified multiple opportunities for health system strengthening activities that directly promote better governance in terms of transparency, capacity, accountability, and participation. Given the resources and opportunities in the health sector, USAID's health program will not merely be integrated with activities in governance reform and economic growth, but can serve as a model sector for strengthening governance.

The team provides recommendations in health financing, essential drugs, service delivery and public-private partnerships. The team provides recommendations in health financing, essential drugs, service delivery and public-private partnerships. These recommendations were reviewed and discussed with Angolan stakeholders at the stakeholder workshop on the last day of the assessment. See the workshop agenda in Annex D, and the presentation in English and Portuguese (Annex J)

For the governance agenda, these interventions aim to strengthen the vertical linkages of government, from the national MOH level to the provincial and municipal governments to the community level, in selected provinces. For the health agenda, these interventions seek to improve the quality and population coverage of PHC to increase the impact of USAID investments in malaria, HIV/AIDS, and family planning.

[25] Based on Mission analysis of the sources of fragility in Angola: weak governance, limited economic opportunity, and inadequate/inequitable access to quality social services.

5.1 Health Financing

The team recommends several specific activities in health financing that can improve transparency, capacity, and accountability.

Planning and budgeting. Currently, health planning and budgeting is a non-participatory top-down process that under-utilizes health information for rational allocation of resources. The decision-making process is not fully transparent. There is little accountability, so budgets are not fully funded. There is weak capacity at all levels to translate MOH strategies or health data into operational plans and budgets, hampering implementation. To address these issues, since 2004 the EU has trained provincial health authorities in five provinces to prepare budget proposals, resulting in an increase in their health budgets for 2006. In addition, in 2005 UNICEF initiated a program to strengthen health planning and management at the municipal level. USAID could build on these efforts in selected provinces. The approach calls for training provincial health authorities in data analysis, operational planning, and budgeting. It also includes improving the information flow between the provincial level and the municipal and facility levels so local needs are fully reflected in provincial budget requests. This activity should include links with existing MOH norms that define levels of care (staff, equipment, service mix, etc. for health posts, centers, and hospitals), which drives the cost structure of the facility. There is a particularly urgent need to cover the recurrent costs at PHC facilities for very basic supplies, equipment, and electricity/water – the absence of which is a barrier to minimal quality of care, discourages health worker motivation, and encourages high user fees that are a financial barrier to access PHC.

Performance monitoring. As a result of the decentralization reforms, the MOH does not monitor performance of the provincial level in terms of resource planning, budget execution, and resource allocation. This function was to be assumed by the municipal level and the citizenry. Our interviews indicate that the municipal level lacks the capacity to assume this responsibility, and thus does not present a fruitful channel of communication for local citizens. The lack of municipal-level representation is likely a prime contributor to the inefficient allocations by the provincial level to the primary care level. Therefore, the team recommends building capacity at the municipal level to articulate local needs to the decision makers at the provincial level. Municipal officials must have the ability to analyze the data that they collect from the health facilities in their jurisdiction. Complementing quantitative data (epidemiological and utilization), there must be an open channel in which health centers, clinics, and municipal hospitals can voice their concerns and needs to the municipal level. Citizens must also be able to express their concerns about the quality and appropriateness of health services. Finally, the municipal level must be able to process this information and advocate for the appropriate resources.

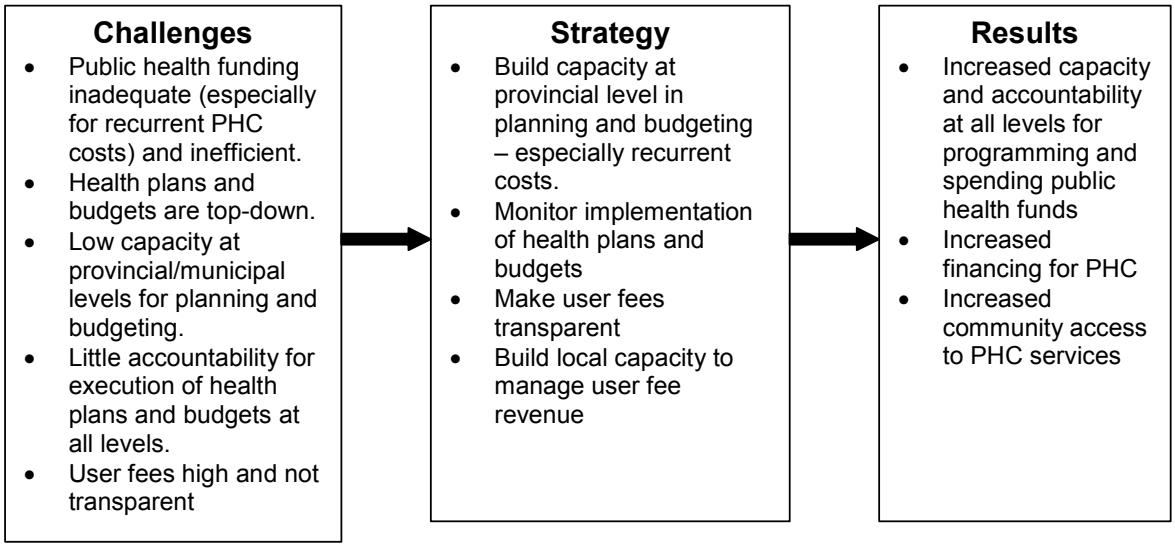
Building this capacity would improve the planning/budgeting activity described above, promote more rational resource allocation based on health data, and increase accountability at all levels.

User fees. As discussed, there is evidence that user fees, as currently practiced, are a financial barrier for poor patients to access PHC. Fees are arbitrary, charged at multiple points in the delivery system, and not formally accounted for. User fees cannot be eliminated because they are now the primary means by which PHC facilities cover basic recurrent costs (supplies, electricity). However, the previously described activities (performance monitoring and planning/budgeting) will likely result in reduced user fees, as clinics/posts/municipal hospitals will have more resources.

The team recommends building on lessons learned from the USAID Maternal–Child Health project's recent (2005) experiences in three provinces in Luanda to reform user fees in selected clinics. Reforms that can improve transparency and increase local capacity to manage resources

include: posting a price list, establishing a single secure fee collection point, and building capacity at the facility level for accounting and managing fee revenue.

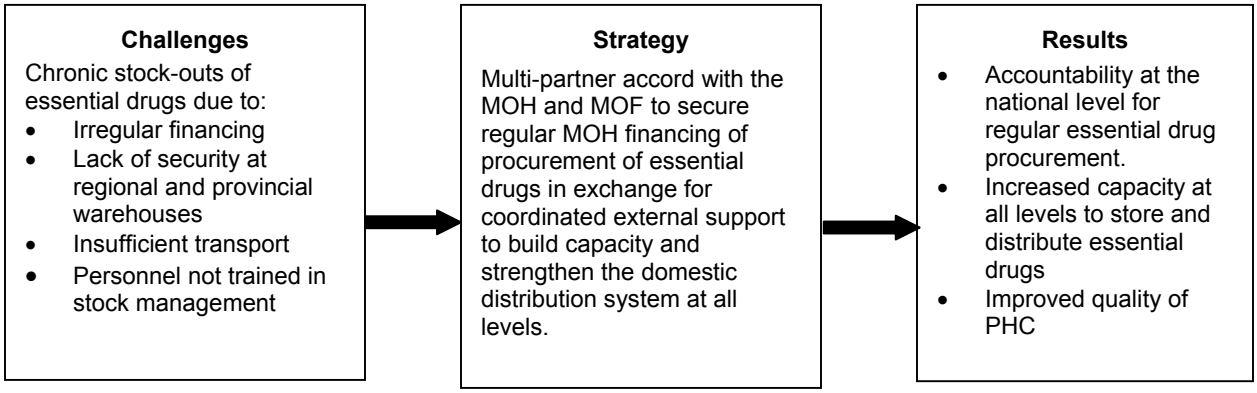
Figure 14. Health Financing



5.2 Essential Drugs

The chronic lack of essential drugs and supplies at the PHC level is a major health system issue in Angola. Stock-outs lead to enormous inefficiencies as thousands of health workers and consumers individually buy small, expensive quantities of drugs in the formal and informal markets. Stock-outs also result in poor service quality and higher user fees, which together act to depress utilization of PHC services. This also is a major obstacle to alleviating the primary causes of morbidity and mortality – malaria, diarrhea, and infectious diseases. Two causes were identified. First, while the MOH has demonstrated capacity to implement its stated procurement process, regular financing to procure essential drugs is not available because decision makers see higher priorities. Second, even if the procurement were done on a timely basis, the distribution system suffers from lack of technical capacity, security, storage, and vehicles to deliver the drugs throughout the service delivery network. The team recommends that USAID collaborate with strategic partners (e.g., UNDP for the Global Fund to Fight AIDS, TB and Malaria) to negotiate an accord with the MOH and MOF that assures regular financing of essential drug procurement in exchange for a program of coordinated external support to strengthen the domestic distribution system. This approach leverages the sizeable assistance of the Presidential Malaria Initiative and the Global Fund, the success of both highly dependent upon a functioning system of drug procurement and distribution. It builds accountability at the national level for essential drug procurement and capacity at the subnational levels in drug logistics and distribution.

Figure 15. Essential Drugs



5.3 Service Delivery

The morbidity and mortality rates found in Angola truly threaten any progress on governance and economic growth. As articulated in USAID's Framework for Africa, a healthy population is necessary for economic productivity and development of democratic practices. Sick, hungry citizens cannot work and are not empowered to push for government accountability. Service delivery is a key point in the health system where the system does or does not produce health at the people level. At the facility level, the assessment found significant barriers to the health service network's capacity to promote health (see Figure 16). The recommendations in health financing and essential drugs will address several of these barriers. In addition, the team recommends a two-pronged approach to implementing specific actions articulated in the MOH's own "Strategic Plan for Accelerated Reduction of Maternal and Infant Mortality" released in April 2004:

"The main strategies for improving the technical quality of care, the satisfaction of the users, the motivation of staff, and increased effectiveness of health interventions are the training of human resources and following their performance. The actions envisaged include:

- *On-the-job training of staff currently working in the public, NGO and church networks;*
- *Formative supervision of trained staff;*
- *Regular assessments and continual monitoring of the quality of care and user satisfaction;*
- *Revision of the curriculum and incorporation of up-to-date norms and methodologies in the mid-level and higher technical nursing schools and in the medical faculty.*

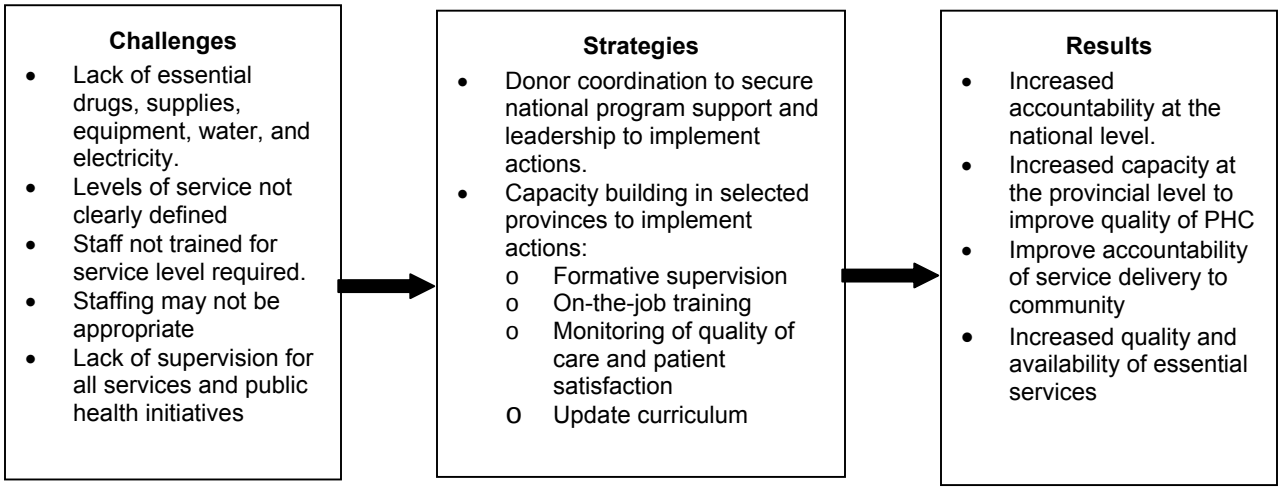
The first three actions will bear fruit in the short term, and the fourth in the medium and long term".

The team found support for these actions among the major partners, the MOH, including the Human Resources Directorate, and the provincial authorities. However, previous attempts to implement them have not progressed; for example, the EU produced a guide for integrated supervision in 2003 that is not used. A major barrier to implementation is the vertical structure of the national health programs (e.g., separate programs for malaria, HIV/AIDS, reproductive health, IMCI,

polio, immunization, surveillance) with strong vested interests at the national level fueled in part by vertical external funding and reporting. For example, there are strong incentives (i.e., per diem for trainers and trainees) to conduct expensive, offsite trainings of relatively few health workers with little connection to application of skills in the facility.

The first prong consists of donor coordination at the national level under MOH leadership to direct the national program leaders to support implementation of the actions listed above. Their support, involvement, and technical expertise are critical to success. USAID may have particular influence on malaria, HIV/AIDS, and reproductive health. The second prong is capacity building at all levels within selected provinces to implement the proposed actions. Such an effort could include staff at the provincial hospital, nursing school, provincial health directorate, and even at the municipal level. Focusing on the provincial-level of the health care network will help to reinforce linkages between the different local institutions that contribute to quality care and help to strengthen referral between levels of care. These actions will increase the quality and availability of essential health services, producing people-level impact in the short term.

Figure 16. Service Delivery



5.4 Public–Private Partnerships

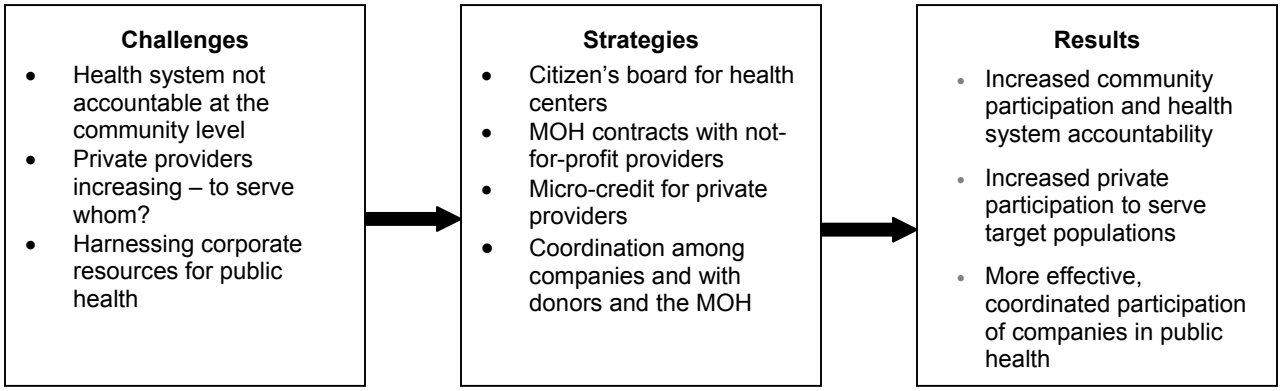
Health Center Citizen's Board. The first option seeks to strengthen the capacity of civil society to organize, participate, and influence decisions in health in their community. The team learned of some successful experiences among international NGOs: Save the Children's support of women's groups to influence community action to protect vulnerable children and Development Workshop's support of community representation on municipal councils to address environmental health problems like water supply. As a complementary component to the preceding strategies in service delivery and health financing, the team recommends exploring formation of a health center citizen's group or board. The citizen's group could participate in determining how to spend user-fee revenues and community health priorities for planning and budgeting, and assist with community outreach efforts. The MOH and USAID's international NGO partners should be consulted on feasibility of establishing a health center citizen board as this idea was not discussed at the stakeholder workshop. If viable, the citizen's boards would increase accountability and participation at the community level.

MOH and non-profit contracts. The second recommendation builds on existing successful partnership between the MOH and Catholic entities to operate hospitals. The Catholic entity manages the hospital and provides supplies, equipment, and maintenance. The hospital staff (doctors, nurses, technicians) are government employees paid by the government. Those interviewed suggest that quality is high and user fees are the same or lower for equivalent care found in private for-profit hospitals. USAID could support replication of this arrangement in locations where the current public service network is non-existent.

Micro-credit for private providers. USAID could structure its micro-credit efforts under SO2 to target private doctors or nurse midwives, or local NGOs or faith-based organizations that are involved in service delivery. A criterion for eligibility could be location in areas where health services are scarce. This would expand private sector participation as well as population coverage, and improve the quality of PHC services.

Harnessing corporate resources. USAID has a partnership with Esso for selected health sector activities. There are several corporations pursuing various health programs like IEC (information, education, communication) for malaria and HIV prevention, but potentially in an unorganized manner; corporate representatives that were consulted could not name a single forum for coordinating their social programs, among each other or with the appropriate ministry. It would be in USAID's interest to use its influence to encourage companies to improve coordination with donor and government efforts in the same areas.

Figure 17. Public-Private Partnerships



5.5 Health Information

In addition to the activities presented, the team recommends that USAID address key information gaps in the health system.

Demographic and Health Survey. There are key information gaps for all stakeholders in the health system. The team applauds Mission plans to conduct a DHS. The team strongly recommends including the module on household health expenditures in the DHS questionnaire. Utilization of private providers and out-of-pocket expenditures on health are suspected to be significant, but there is no nationally representative data on these questions.

Facility mapping. Another data gap is an inventory of the public and private service delivery network. Luanda province just completed an inventory of public and private health facilities that can now inform decisions about allocation of staff, funds, and drugs/supplies. The MOH is very interested in replicating the inventory in other provinces. This information would be an extremely useful input to many of the recommended activities in USAID's selected provinces.

Cost of primary care. As stated earlier, one of the root causes of high user fees and poorly equipped PHC centers is the lack of any non-salary recurrent cost support from the provincial level to the PHC level. During the course of our interviews, it became clear that some central-level officials felt that user fees were generating enough revenue for health facilities to be functional. Our own analysis found it difficult to assess whether or not this was the case. Therefore, we believe that it is critical to study the cost of delivering adequate primary care at the health center/post level as well as the level of user fee revenue and what the revenue is used for. Understanding the cost structure and requirements will provide health facilities with evidence to lobby policymakers.

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Annex B: Contact List

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Annex C: Group Discussion with NGOs

Health Systems Assessment for USAID/Angola

August 11, 2005

Participants

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Catherine Connor, Partners for Health Reform*plus* Project, Abt Associates

Yogesh Rajkotia, John Hopkins Fellow, USAID GH/HIDN

Background

SOW: August 8–19. Broad assessment of Angola's health system including governance, financing, human and physical resources, pharmaceuticals, HIS, and private sector. The findings will inform the Mission's new health strategy for 2006-2011.

Why: Health System Assessment SOW: August 8–19. Angola is in transition from humanitarian to development assistance. Opportunity to integrate interventions to strengthen the health system into disease/service specific programs. We are doing a broad assessment of Angola's health system including governance, financing, human and physical resources, pharmaceuticals, HIS, and private sector to inform the Mission's new health strategy for 2006-2011. Civil society and private non-profit sector are already significant players in the health system, and key to improving health system performance in terms of access, equity, quality, efficiency, and sustainability.

Questions/Issues

1. Donor and NGO coordination in the health sector – are there forums to share information, increase complementarity – national level, provincial level.

   At the national level, the Interagency Coordination Committee meets weekly with the Vice-Minister of Health (Dr. Van-Dunem) at the DNSP and since 2004 has been open to discussing all public health issues. No one mentioned UTCHA, TCU, CONGA, or FONGA.

   At the provincial level, there is a lot of variability. Government-led coordination of NGO activities depends highly on the motivation and capacity of the DPS (*Direccao Provincial de Saude*) officials. Works well in Huambo (weekly meetings chaired by DPS on health, nutrition and security), Bie (weekly subgroup meetings on health and nutrition chaired by the Public Health Director of the DPS), Benguela, and Luanda. Coordination in some provinces is inconsistent or non-existent.

   At the municipal level, it is more effective to work with the Municipal Administrator who has more authority, compared to the *Seccao Municipal de Saude*.

2. Government attitude towards NGOs in health at national level? Provincial or municipal level? Concrete examples of government partnership, collaboration.

   Relations are generally good. During the war, the government had some negative experiences with international NGOs and there has been a trend to exercise more control over NGO activities. NGOs experience competence and good will among many government staff in Luanda at MOH and the Provincial Health Directorate (DPSL). Competence and motivation definitely vary and decline as you move down the hierarchy from Luanda to other provinces and municipalities.

   There are several examples of successful partnership between the MOH and Catholic entities to operate hospitals. The Catholic entity manages the hospital and provides supplies, equipment, and maintenance. The hospital staff (doctors, nurses, technicians) are government employees paid by the government. Quality is high and user fees lower than those found in purely public hospitals. The group mentioned a hospital in Cubal (Benguela Province), Divina Providencia Hospital in Luanda city, the Italian Catholic Hospital in K. Kashi (Luanda province), and Seles Hospital in Cuanza Sul province.

3. Policies, laws, regulation of civil society organizations. Exist? Clear? Enforced? Conducive or obstacle to growth?

   The laws and regulations for NGOs is a "long saga." Compliance and enforcement are uneven. The new NGO law would allow the government to take retributive action if it chose to. The group was not aware of any case where the government did take any action against any international NGO.

4. Opportunities for NGOs/Civil Society/Religious organizations to increase public sector accountability to community?

   There is a serious lack of information and awareness among the population outside of Luanda. One NGO reported doing a community meeting and the participants were surprised to learn that Angola had oil and significant oil revenues. Another suggestion is to clearly communicate to the beneficiary population and government counterparts exactly what are the roles and responsibilities of each party – the private NGO and the government – so the population will look to the government to fulfill their commitment. This same advice was echoed in the corporate discussion group held later today when Oderbrecht reported training 100 community health agents for a provincial government for free (the training, materials, hats and t-shirts), but then the agents expected Oderbrecht to provide employment.

5. Working with Angolan NGOs

   Strengths of Angolan NGOs include their credibility with the community and reach, and their technical expertise related to their organizational mandate. As a generality, local NGOs are more responsive/dedicated than some of the national NGOs. Weaknesses of the Angolan NGOs are their administrative, organizational/institutional capacity. They can't write proposals, prepare budgets, manage funds, account for how funds are spent, or document well their activities. This weakness makes it difficult for them to receive grants directly from international donors like USAID because they cannot comply with the application and reporting requirements. As a result, funds flow through international NGOs like PSI and Care. Training in administrative skills has not been successful due to staff turnover and lack of interest/absorptive capacity. Successful capacity building requires close working relationship and follow-up ("acompanhamento"). The challenge is to work closely the NGO while ensuring its independence.

Annex D. Stakeholder Workshop Agenda

Health Systems Assessment: Angola
Stakeholder Workshop

Date: Friday, August 19, 2005 8:30–13:00

Venue: Hotel Tropico, Luanda

Purpose: Gather stakeholders that seem critical to the success of the options on the table / impacted by the results; get their buy-in; get their feedback and reactions on findings and recommendations.

Objectives:

- By the end of the day participants will have:
- Reviewed and discussed team's major findings
- Provided input on their priorities, based on strengths and weaknesses discussed
- Provided input into recommendations and identify how they will/can be involved in implementing concrete options; how to move forward OR provided feedback and recommendations on major options presented by team

Audience: (maximum 30 people)

- USAID, MOH, donors, private sector, NGOs

Preliminary Workshop Agenda

Time	Topic	Responsible	Materials
8:30	Coffee/registration		Registration sheet
9:00	Welcome	USAID/MOH	
9:30	Introductions & expectations, overview of objectives & agenda, guidelines for working together		Handout of agenda & objectives Guidelines (pre-prepared)
10:00	Overview of methodology, results and recommendations Highlight key findings Present suggested recommendations Q&A/discussion		Presentation(s) Handouts of slides, write-up of options
10:45	Coffee break		
11:00	Small group discussion: go over recommendations and discuss applicability and feasibility in Angola		Questions for discussion
11:45	Reports from small groups – 10 min each per group		
12:30	Summarize	Team	
12:45	Closing comments	USAID	
1:00	Workshop evaluation. Adjourn for Lunch		Evaluation form

Small Group Discussion Questions

Looking at the strategies listed on the four last slides:

- Which would be the three principal strategies that you would recommend?
- How could your organization collaborate with USAID in these areas?
- What would be your advice to USAID as it begins to work on strengthening the health system?

Workshop Handouts:

- Sign-in registration
- PPTs
- Write-up of options or strategies – 1 page in Portuguese
- Arrange for LCD projector and flipcharts
- Evaluation from (Catherine to ask from KP)

- Guidelines for small group discussions
- Objectives and agenda
- Paper/pens, workshop name and dates

Stakeholder Workshop Participants

Name	Organization	Email	Telephone
Table 1			
João Constancio	Programa Nacioinal de Medicamentos Essenciais/MOH	pme@elanet.net	399 42618 923322746
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Workshop recommendations

Planning and budgeting

- Support the government and its partners in the creation of norms for managing quality health care based on needs according to the desired level of coverage

Pharmaceutical

- Strengthen MOH technical and logistical capacity for drug planning, purchasing, storing, distribution and supervision, promoting bulk regional purchasing

Service delivery

- Strengthen systematic integrated supervision of health units and also activities that involve the community

Private-public partnership

- Finance local NGOs and other partners (e.g., faith-based organizations) to lead health projects at the community level
- Integrate private sector in public health initiatives

Summary of participant feedback of workshop

Fifteen workshop feedback forms were received, including two from USAID mission staff. All except for three workshop participants agreed with the statement "workshop divulged well the findings of the rapid assessment on the Angolan health system." However, comments from the three participants suggested they might be commenting on the degree to which they agreed with the study findings.[26]

All participants felt that participants had the opportunity to review and discuss the findings and offer their opinions. All except for two felt the workshop did a good job of presenting options for USAID to work in health systems strengthening. Four participants commented on the time restriction, and one respondent suggested taking a whole day.

Additional comments included input on the usefulness of working in small groups and the importance of partnership and working closely with MOH programs.

[26] Comments included "More or less," "They need more information about the subject," and "Study more in-depth."

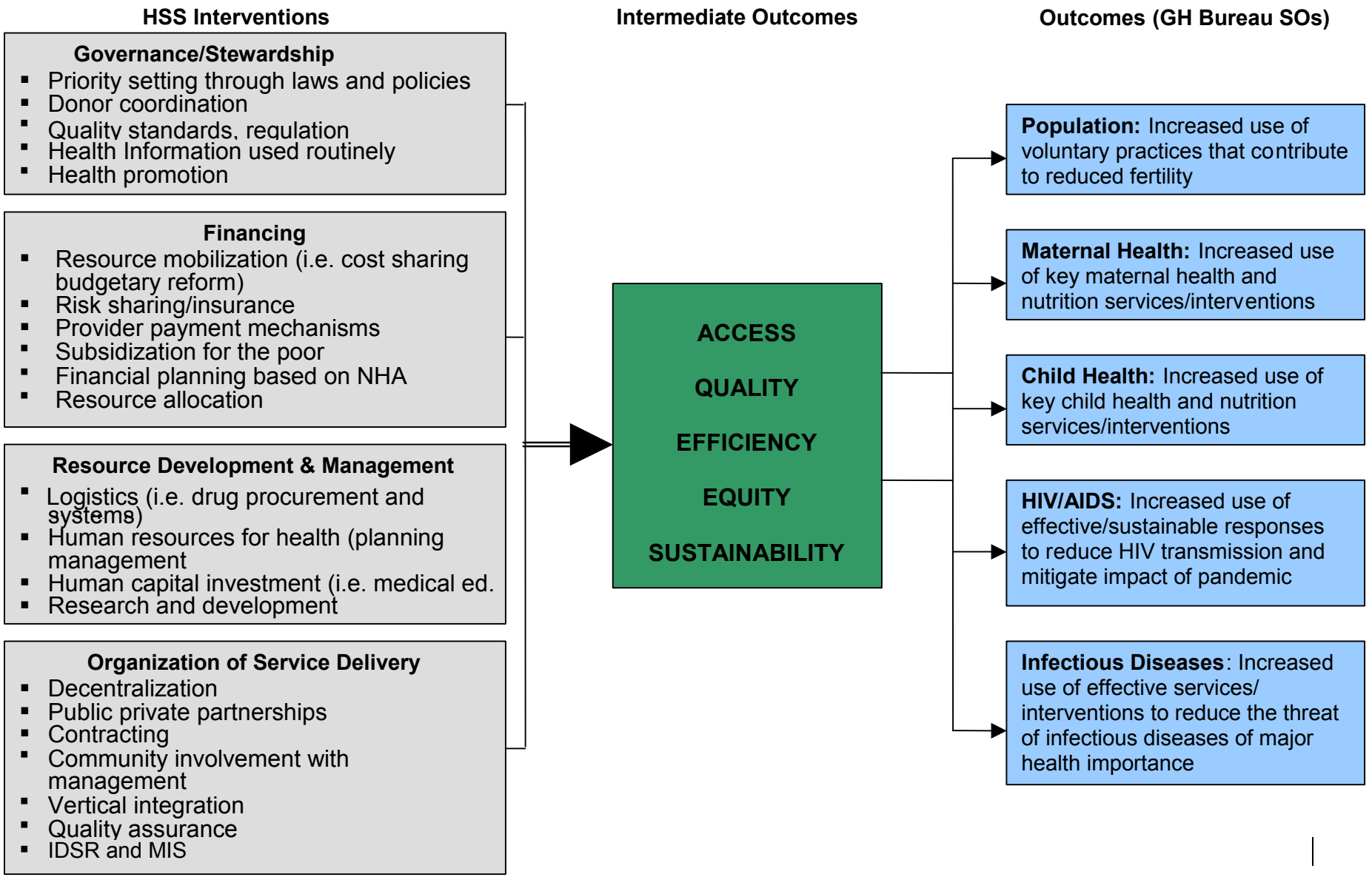
Annex E. Handouts for Overview of Health Systems Strengthening

Overview of Health Systems Strengthening for USAID/Angola

August 15, 2005

APOSTILA

Handouts


HSS Interventions
Governance/Stewardship
Priority setting through laws and policies
Donor coordination
Quality standards, regulation
Health Information used routinely
Health promotion
Financing
Resource mobilization (i.e. cost sharing budgetary reform)
Risk sharing/insurance
Provider payment mechanisms
Subsidization for the poor
Financial planning based on NHA
Resource allocation
Resource Development & Management
Logistics (i.e. drug procurement and systems)
Human resources for health (planning management
Human capital investment (i.e. medical ed.
Research and development
Organization of Service Delivery
Decentralization
Public private partnerships
Contracting
Community involvement with management
Vertical integration
Quality assurance
IDSR and MIS
Intermediate Outcomes
ACCESS
QUALITY
EFFICIENCY
EQUITY
SUSTAINABILITY
Outcomes (GH Bureau SOs)
Population: Increased use of voluntary practices that contribute to reduced fertility
Maternal Health: Increased use of key maternal health and nutrition services/interventions
Child Health: Increased use of key child health and nutrition services/interventions
HIV/AIDS: Increased use of effective/sustainable responses to reduce HIV transmission and mitigate impact of pandemic
Infectious Diseases: Increased use of effective services/ interventions to reduce the threat of infectious diseases of major health importance

Typical System Constraints, Possible Disease or Service-specific and System-wide Responses		
Constraint	**Disease or Service-specific response**	**Health system responses**
Financial barriers:: inability,of clients to pay formal or informal fees	Exemptions/waivers/reduced prices for focal diseases or services	Development of risk pooling strategies like health insurance
Inappropriately skilled staff	Continuous education/ training to develop skills in focal diseases or services	Review of basic medical and nursing training curricula to ensure that appropriate skills are included in basic training.
Poorly motivated staff	Financial incentives to reward delivery of particular priority services	Institution of proper performance review systems, creating greater clarity of roles and expectations regarding performance of roles. Review of salary structures and promotion procedures.
Lack of intersectoral action and partnership	Creation of special disease- or service-focused cross-sectoral committees and task forces at the national level	Building systems of local government that incorporate representatives from health, education, and agriculture, and promote accountability of local governance structures to the people.
Poor quality care amongst private sector providers	Training for private sector providers in focus diseases or services	Development of accreditation and regulation systems

GROUP EXERCISE

USAID/Angola: HIV/AIDS, Malaria, and Family Planning
System Constraints, Disease or Service-specific and
System-wide Responses

Constraints	Disease or Service-specific Responses	Health System Responses
	List main interventions proposed for USAID/Angola to address HIV/AIDS, Malaria and Family Planning	

Participant Evaluation Form

This is the first time we have conducted this session on health systems for USAID Mission staff. We would like to improve – please take a moment to give us your opinion. *Esta foi a primeira vez que conduzimos esta sessao sobre o sistema de saude para o equipe de uma Missao da USAID. Procuramos melhorar. Por gentileza, gostariamos conhecer sua opinao*.

What work well? (presentation content, group exercises, other)

O que funcionou bem? (ex. O conteudo da apresentacao, os execisios de groupo)

What can we do better? What should we change? Drop?

O que podemos melhorar? O que nos deveriamos mudar? Omitir?

THANK YOU! *MUITO OBRIGADO*

Annex F. Donor Programs in Angola

Donor	Project Descriptions	Timeline	Future Projects	Project Location
MULTILATERAL DONORS / ORGANIZATIONS				
Global Fund for AIDS, TB, Malaria	Malaria (Round 3) - $38 M (requested) $28M approved HIV/AIDS (Round 4) - $92 M (requested) $28M approved Tuberculosis (Round 4) - $11 M (requested) $7M approved UNDP is the principal recipient with $1.9M earmarked for strengthening the MOH	2006-07		National
UNDP	Strengthening Education System to Combat HIV/AIDS, Min of Ed., $3.4 M Strengthen the MOH as part of the Global Fund awards			
UNICEF	Supporting Government's Strategic Plan in the following areas: Expanded Programme on Immunization (EPI), National Measles Campaign; IMCI, malaria control, Nutrition and Child Health Days, Safe Motherhood Strengthening of health system and capacity development: Revitalize municipal health services: 1) Baseline data collection re health status and current supply of health services (public and private); 2) Define catchment area for each health facility; 3) Municipal health plan; 4) Identify and mobilize resources through government budget; 5) Implement municipal health plan that includes community activities and supervision by municipality	ongoing		National
World Health Organization	Immunizations with a major emphasis on polio. Objective is to support surveillance, routine immunization and all activities related to routine immunization. Planning consultation from Brazil to help strengthen cold chain system. Maternal and child health: working in micro-nutrients and supplying de-worming medicine. Want to provide support to MOH for IMCI and maternal/neonatal health – specifically to integrate "Road Map to Health" into the national plan. Malaria: supporting personnel at the provincial level who provide technical support. HIV/AIDS: supplies technical support when requested. Collaborated on HIV/AIDS sentinel surveillance system, proposing to do a study on antiretroviral drugs. Other: 1) WHO works with the MOH to obtain TB drugs from the Global Drug Fund and 2) WHO provides technical assistance to the MOH in this area of sleeping sickness.	N/A	Planning to do a census of health facilities, seven in Luanda, six in Bie and seven in Huila.	National
BILATERAL DONORS / ORGANIZATIONS				
European Union	Working on both the national and provincial level. National programs: PESS (strategic plan for health sector) – 5 yr plan. Medicinal system – working with MoH to provide generic drugs as opposed to solely providing health kits. Strengthening blood bank system	2004-07	N/A	Luanda, Benguela, Huila, Huambo, Bie

Donor	Project Descriptions	Timeline	Future Projects	Project Location
	Building a nursing school Provincial level (5 provinces: Huambo, Luanda, Benguela, Huila, and Bie) Working to develop provincial work plans within the public health sector. Capacity building and quality of care Working to develop a liaison b/w the MoH and NGOs Allocated 14 million Euros to support national rehabilitation program from 2003-2007			

Annex G. Map of MOH Strategy and Donor Inputs (other than USAID) for Health System Strengthening

	Donors				MOH	
	WHO	**UNICEF**	**EU**	**UNDP**	**Strategic Plan for the Accelerated Reduction of MMR and IMR**	**Sector Development Plan 2002-05**
National health policy and strategy	**X**		**X**	As the principal recipient of the first round of Global Fund funds, UNDP will design a program to strengthen the MOH and health system. Program to be implement-ed over 2006-2007.	**X**	**X**
Norms and protocols	**X**	**X**	**X**			
Increase coordination and managerial capacity among the vertical public health programs		**X**				
Increase integration and coordination between the vertical public health programs and the provincial health directorates		**X**	**X**		**X**	
Basic and/or financial management training – any level		**X**	**X**		**X**	
Clinical training (reproductive health, IMCI, malarial case management, and other public health areas)	**X**	**X**			**X**	
Development of provincial health plans that are linked to budget			**X**			
Provincial supervision of health facilities					**X**	
Provincial supervision of municipalities		**X**			**X**	
Development of municipal health plans that are linked to budget		**X**				
Municipal supervision of health facilities		**X**			**X**	
Mapping of all health facilities in the municipality		**X**	**X**		**X**	
Health profile of municipal population					**X**	

Partnership with private providers					**X**	
Community participation and/or health agents		**X**			**X**	

Annex H. Comparative Indicators for Angola and SSA

	Angola			Sub-Saharan Africa[1] Average		
	Indicator Value	**Year**	**Source**	**Indicator Value**	**Year**	**Source**
CORE						
Total population	13,522,110	2003	WDI	14,989,743	2003	WDI
Population growth rate (annual %)	3.0	2003	WDI	2.1	2003	WDI
Rural population (% of total population) - 2003	63.8	2003	WDI	61.8	2003	WDI
Urban population (% of total population) - 2003	36.2	2003	WDI	38.2	2003	WDI
Life Expectancy at birth (years)	40	2003	WDI	49	2003	WDI
Fertility rate, total (births per woman)	7	2002	WDI	5	2002	WDI
Infant mortality rate (per 1000 live births)	154	2000	WDI	92	2000	WDI
Maternal mortality rate (per 100,000)	1,700	Regression estimates	WDI	914	Regression estimates	WDI
Contraceptive prevalence (% of women ages 15-49)	6.00	2003	WDI	22.92	2003	WDI
Prevalence of HIV, total (% of population aged 15-49)	3.90	2003	UNICEF 2005	8.65	2003	UNICEF 2005
GDP per capita	975	2003	WDI	1,073	2003	WDI
Per capita total expenditure on health at international dollar rate	92	2002	WHR 2005	115	2002	WHR 2005
STEWARDSHIP						
CPI Score[4]	2.00	2004	Transparency International CPI	2.84	2004	Transparency International CPI
Governance Indicators:			Governance Indicators for 1996-2004, World Bank			Governance Indicators for 1996-2004, World Bank
Voice and Accountability						
Point estimate[2]	-1.02	2004		-0.57	2004	
Percentile rank[3]	21.40	2004		32.70	2004	
Political Stability						

Point estimate[2]	-0.95	2004		-0.60	2004	
Percentile rank[3]	18.00	2004		32.79	2004	
Government Effectiveness						
Point estimate[2]	-1.14	2004		-0.74	2004	
Percentile rank[3]	11.50	2004		27.56	2004	
Regulatory Quality						
Point estimate[2]	-1.40	2004		-0.67	2004	
Percentile rank[3]	6.90	2004		29.47	2004	
Rule of Law						
Point estimate[2]	-1.33	2004		-0.77	2004	
Percentile rank[3]	6.80	2004		27.57	2004	
Control of Corruption						
Point estimate[2]	-1.12	2004		-0.65	2004	
Percentile rank[3]	8.40	2004		30.05	2004	
HEALTH FINANCING						
Total expenditure on health as % of GDP	5.0	2002	WHR 2005	5.2	2002	WHR 2005
General government expenditure on health as % of total expenditure on health	41.9	2002		49.5	2002	
External resources for health as % of total expenditure on health	7.9	2002		20.4	2002	
Out-of-pocket expenditure as % of private expenditure on health	100.0	2002		79.8	2002	
Government expenditure on health (% of total government expenditure)	4.1	2002		9.5	2002	
Per capita total expenditure on health at average exchange rate (US$)	38.0	2002		41.6	2002	
Per capita total expenditure on health at international dollar rate	92.0	2002		104.8	2002	
Social security expenditure on health as % of general government expenditure on health	0.0	2002		21.5	2002	
HUMAN RESOURCES AND HEALTH FACILITIES						
Physicians per 100,000	8	1997	WHOSIS	16	Most recent year available	WHOSIS
Nurses per 100,000	114	1997	WHOSIS	79		WHOSIS
Midwives per 100,000	4	1997	WHOSIS	27		WHOSIS
Pharmacists per 100,000	0.2	1997	WHOSIS	3		WHOSIS
Hospital beds per 1,000	1	1990	WDI	1		WDI

PHARMACEUTICALS AND SUPPLIES						
Total expenditure on pharmaceuticals (% total expenditure on health)	20.3	2000	The World Medicines Situation	27.5	2000	The World Medicines Situation
Total expenditure on pharmaceuticals (per capita average exchange rate)	5.0	2000		9.4	2000	
Government expenditure on pharmaceuticals (per capita average exchange rate)	1.0	2000		7.0	2000	
Private expenditure on pharmaceuticals (per capita average exchange rate)	4.0	2000		5.9	2000	
Population with sustainable access to affordable essential drugs (%)	0-49	1999	HDR			
PRIVATE SECTOR ENGAGEMENT						
See Health Financing Module for data on private share of health financing, expenditures, out-of-pocket expenditures, per capita health expenditure, etc.						
See Health Resources Module for data on number of private providers, mix of health professionals (MDxRN, MD specialists x GPs)						
Type of health services used by income group in Angola:						
% who used a private provider	Total: 41.5%; Very poor: 33.2%; Moderately poor: 36.5%; Above poverty line: 50.4%	1995	Anglola NIS Survey			
% who used a public provider	Total: 34.9%; Very poor: 30.3%; Moderately poor: 37.2%; Above poverty line: 31.9%					
% who did not seek care	Total: 24%; Very poor: 35.9%; Moderately poor: 26.1%; Above poverty line: 17.7%					
% of household income spent on health by income group in Angola	Total: 5.4%; Very poor: 3.8%; Moderately poor: 5.2%; Above poverty line: 6.2%					

HEALTH INFORMATION SYSTEMS						
Hospital beds per 1,000	1.30	1990	WDI	0.73		
HIV prevalence among pregnant women aged 15-24	n/a			17.02	Most recent year available	UNICEF 2003
Contraceptive prevalence rate	6.00	2003	WDI	22.92	2003	WDI
Proportion of children under 5 years who are underweight for age	30.50	2001	WHS 2005	25.78	Most recent year available	WHS 2005
Maternal mortality ratio reported by national authorities	n/a			643	Most recent year available	UNICEF 2003
Percentage of surveillance reports received at the national level from districts compared to number of reports expected	96.00	2003	WHO VPD Monitoring System	90.14	Most recent year available	WHO VPD Monitoring System

[1] Sub-Saharan Africa includes 47 countries: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

[2] Ranges from -2.5 to 2.5

[3] Percentile rank indicates the percentage of countries worldwide that rate below the selected country (subject to margin of error)

[4] Perceptions of the degree of corruption as seen by business people and country analysts. Ranges between 10 (highly clean) and 0 (highly corrupt).

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Annex I. 2005 Contents of the Three Types of Drug Kits Provided under the National Essential Drug Program (NEDP)

Health Post Kit

1. Acido acetilsalicílico (Aspirina) - Comprimido - 500 mg 3 (Frasco de 1000 Comprimido) 3.000
2. Acido salicilico e benzóico - Pomada - 35 (Bisnaga de 36g) 35
3. Adrenalina - Injectavel - 1 mg/ml 2 (Amp. Inj. de 1ml) 2
4. Agua por inj. - Amp. Inj. de 5ml - 1 (Caixa de 100 Amp. Inj. de 5ml) 100
5. Amoxicilina - Comprimido - 250 mg 1 (Frasco de 1000 Comprimido) 1.000
6. Amodiaquina - Comprimido - 200 mg 4 (Frasco de 1000 Comprimido) 4.000
7. Atropina (sulfate) - Comprimido - 1 mg 5 (Frasco de 100 Comprimido) 500
8. Benzoat de benzilo - Solução - 0,25 1 (Frasco de 1litro) 1
9. Clorfeniramina (maleate) - Comprimido - 4 mg 2 (Frasco de 100 Comprimido) 200
10. Clorexidina (digluconate) - Solução - 0,2 2 (Fasco de 100ml) 2
11. Cotrimoxazole - Comprimido - 400 + 80 mg 3 (Frasco de 1000 Comprimido) 3.000
12. Preservativos lubrificados (diam. 52mm) * - - 10 (Emb. de 100) 1.000
13. Fenoximetilpenicilina - Comprimido - 500 mg 1 (Frasco de 1000 Comprimido) 1.000
14. Magnesium Trisilicate Comp. - Comprimido - 500 mg 1 (Frasco de 1000 Comprimido) 1.000
15. Lidocaina - Injectavel - 0,01 2 (Frasco Inj. de 50ml) 2
16. Mebendazol - Comprimido - 100 mg 1 (Frasco de 1000 Comprimido) 1.000
17. Metronidazole - Comprimido - 250 mg 1 (Frasco de 1000 Comprimido) 1.000
18. Paracetamol - Comprimido - 500 mg 3 (Frasco de 500 Comprimido) 1.500

19. Penicilina procaina - Injectavel - 1 g 100 (Vial) 100
20. Sais de reidratacao oral - Pó - 300 (Pacote) 300
21. Sulfato Ferroso + ácido fólico - Comprimido - 200 + 0,25 mg 5 (Frasco de 1000 Comprimido) 5.000
22. Salbutamol - Comprimido - 4 mg 2 (Frasco de 100 Comprimido) 200
23. Sulfadoxina + pirimetamina - Comprimido - 500 + 25 mg 3 (Frasco de 500 Comprimido) 1.500
24. 2Tetraciclina (HCl) oftálmica - Pomada - 0,01 50 (Bisnaga de 5g) 50
25. Violeta de genciana - Pó - 2 (Frasco de 25g) 2
26. Oxido de zinco vaselina - Pomada - 0,1 5 (Bisnaga de 100g) 5
27. Multivitamina - Comprimido - 1 (Frasco de 1000 Comprimido) 1.000
28. Adhesivo - - 10 (Rolo 25mm x 5m) 10
29. Algodão - - 3 (Pacote 500g) 3
30. Gaze - - 1 (Rolo 1m x 100m) 1
31. Ligadura - - 100 (Rolo 10cm x 5m) 100
32. Agulha IM descartavel - - 150 (21G x 1,5) 150
33. Agulha subcutanea descartavel - - 5 (23G x 1) 5
34. Seringa descartavel - - 5 (1ml) 5
35. Seringa descartavel - - 150 (5ml) 150
36. Fio de sutura, seda c/agulha - - 15 (nº 00) 15
37. Laminas de bisturi - - 5 (nº 22) 5
38. Luvas cirurgicas - - 20 (nº 7,5) 20
39. Sabonete - - 10 () 10
40. Saquinhos para Medicamentos - - 10x8cm 40 (Saco de 100) 4.000
41. Bloco de papel - - 2 () 2
42. Esferográficas - - 4 () 4

Health Center Kit

1. Acido acetilsalicílico (Aspirina) - Comprimido - 500 mg 3 (Frasco de 1000 Comprimido) 3.000
2. Acido salicilico e benzóico - Pomada - 35 (Bisnaga de 36g) 35
3. Adrenalina (Epinefrina) - Injectavel - 1 mg/ml 5 (Amp. Inj. de 1ml) 5
4. Agua para inj. - Amp. Inj. de 5 ml - 2 (Caixa de 100 Amp. Inj. de 5 ml) 200
5. Amodiaquina - Comprimido - 200 mg 4 (Frasco de 1000 Comprimido) 4.000
6. Amoxicilina - Comprimido - 250 mg 1 (Frasco de 1000 Comprimido) 1.000
7. Atropina (sulfate) - Comprimido - 1 mg 5 (Frasco de 100 Comprimido) 500
8. Benzoat de benzilo - Solução - 0,25 1 (Frasco 1litro) 1
9. Clorfeniramina (maleate) - Comprimido - 4 mg 2 (Frasco de 100 Comprimido) 200
10. Clorexidina (digluconate) - Solução - 0,2 2 (Frasco de 100ml) 2
11. Cotrimoxazole - Comprimido - 400 + 80 mg 3 (Frasco de 1000 Comprimido) 3.000
12. Preservativos lubrificados (diam. 52mm) * - - 10 (Emb. de 100) 1.000
13. Diazepam - Injectavel - 2 mg/ml 2 (Amp. Inj. de 2ml de 5 Injectavel) 10
14. Metylergometrina - Comprimido - 0,125 mg 1 (Frasco de 100 Comprimido) 100
15. Fenoximetilpenicilina - Comprimido - 500 mg 1 (Frasco de 1000 Comprimido) 1.000
16. Magnesium Trisilicate Comp. - Comprimido - 500 mg 1 (Frasco de 1000 Comprimido) 1.000
17. Lidocaina - Injectavel - 0,01 2 (Frasco de 50ml) 2
18. Mebendazol - Comprimido - 100 mg 1 (Frasco de 1000 Comprimido) 1.000
19. Metronidazol - Comprimido - 250 mg 1 (Frasco de 1000 Comprimido) 1.000
20. Paracetamol - Comprimido - 500 mg 3 (Frasco de 500 Comprimido) 1.500
21. Penicilina procaina - Injectavel - 1 g 200 (Vial) 200
22. Prometazina - Injectavel - 25 mg/ml 2 (Ampola de 2ml de 5 Injectavel) 10
23. Sais de reidratacao oral - Pó - 300 (Pacote) 300
24. Sulfato ferroso + acido fólico - Comprimido - 200 + 0,25 mg 6 (Frasco de 1000 Comprimido) 6.000

25. Salbutamol - Comprimido - 4 mg 2 (Frasco de 100 Comprimido) 200
26. Sulfadoxina + pirimetamina - Comprimido - 500 + 25 mg 3 (Frasco de 500 Comprimido) 1.500
27. Tetraciclina (HCl) oftálmica - Pomada - 0,01 50 (Bisnaga de 5g) 50
28. Violeta de genciana - Pó - 2 (Frasco de 25g) 2
29. Oxido de zinco vaselina - Pomada - 0,1 5 (Bisnaga de 100g) 5
30. Multivitamina - Comprimido - 1 (Frasco de 1000 Comprimido) 1.000
31. Adesivo - - 10 (Rolo 25mm x 5m) 10
32. Algodão - - 3 (Pacote 500g) 3
33. Gaze - - 1 (Rolo 1m x 100m) 1
34. Ligadura - - 100 (Rolo 10cm x 5m) 100
35. Agulha intramuscular descartavel - - 300 (21G x 1,5) 300
36. Agulha subcutanea descartavel - - 30 (23G x 1) 30
37. Seringa descartavel - - 10 (1ml) 10
38. Seringa desceartavel - - 300 (5ml) 300
39. Fio de sutura, seda c/agulha - - 15 (nº 00) 15
40. Laminas de bisturi - - 5 (nº 22) 5
41. Luvas cirurgicas - - 20 (nº 7,5) 20
42. Sabonete - - 15 () 15
43. Saquinhos para Medicamentos - - 10x8cm 40 (de 100) 4.000
44. Bloco de papel - - 2 () 2
45. Esferográficas - - 4 () 4

Complementary Kit (For Municipal Hospitals With Physicians On Staff)

1. Ac.Folico - Comprimido - 5 mg 1 (Frasco de 1000 Comprimido) 1.000
2. Ac. Nalidixico - Comprimido - 500 mg 3 (Frasco de 100 Comprimido) 300

3. Aminofilina - Injectavel - 25 mg/ml 10 (Amp. Inj. de 10ml) 10
4. Cimetidina - Comprimido - 200mg 3 (Frasco de 100 Comprimido) 300
5. Cloranfenicol - Amp. Inj. - 1 g 5 (Caixa de 5 Amp. Inj.) 25
6. Dexametasona - Amp. Inj. - 4mg/ml 5 (Frasco de 100 Amp. Inj.) 500
7. Diazepam - Comprimido - 5mg 1 (Frasco de 500 Comprimido) 500
8. Ergometrina maleato - Amp. Inj. de 1ml - 0,2mg/ml 5 (Caixa de 5 Amp. Inj. de 1ml) 25
9. Fenobarbital - Comprimido - 30mg 1 (Frasco de 500 Comprimido) 500
10. Gentamicina - Amp. Inj. de 2ml - 80 mg/2ml 10 (Caixa de 5 Amp. Inj. de 2ml) 50
11. Glucose com sistema - Solução - 0,05 25 (Balão 500ml) 25
12. Griseofulvina - Comprimido - 500mg 1 (Frasco de 100 Comprimido) 100
13. Hidroclorotiazida - Comprimido - 25mg 1 (Frasco de 1000 Comprimido) 1.000
14. Lactato de Ringer com sistema - Solução - 15 (Balão 500ml) 15
15. Metoclopramida - Amp. Inj. de 2ml - 5mg/ml 1 (Caixa de 5 Amp. Inj. de 2ml) 5
16. Nifedipina - Comprimido - 10 mg 1 (Frasco de 100 Comprimido) 100
17. Penicilina Benzatinica - Frasco Inj. - 2.4 MUI 10 (Vial) 10
18. Penicilina Procaina Benzyl - Injectavel - 3 MUI 20 (Vial) 20
19. Prednisolona - Comprimido - 5 mg 1 (Frasco de 100 Comprimido) 100
20. Probenicid - Comprimido - 500mg 1 (Frasco de 100 Comprimido) 100
21. Propranolol - Comprimido - 40 mg 1 (Frasco de 500 Comprimido) 500
22. Quinina - Comprimido - 300mg 4 (Frasco de 1000 Comprimido) 4.000
23. Quinina dihydrochloride - Amp. Inj. de 2ml - 300mg/ml 5 (Caixa de 5 Amp. Inj. de 2ml) 25
24. Sulfato de ferro - Comprimido - 200 mg 1 (Frasco de 500 Comprimido) 500
25. Vitamina A (Retinol) - Capsula - 200.000 IU 1 (Frasco de 500 Capsula) 500
26. Agua/injecção - Amp. Inj. de 5ml - 1 (Caixa de 100 Amp. Inj. de 5m 100
27. Agulhas intramuscular - - 2 (20G x 2 de 100) 200
28. Agulhas Subcutanea - - 2 (22G x 1,25 de 100) 200

29. Catetar Foley - - 3 (nº 14) 3
30. Catetar Foley - - 3 (nº 18) 3
31. Catetar Nelaton - - 1 (nº 10) 1
32. Catetar Nelaton - - 2 (nº 18) 2
33. Luvas Cirurgicas - - 8 (nº 7,5) 8
34. Luvas não Cirurgicas - - 10 () 10
35. Saquinhos para Medicamentos - - 10x8cm 4 (de 100) 400
36. Seringas Plasticas - - 50 (2ml) 50
37. Seringas Plasticas - - 50 (5ml) 50
38. Seringas Plasticas - - 2 (10ml) 2
39. Sistema de Soro (para infusão) - - 6 (22G) 6
40. Sonda Naso Gástrica (SNG) - - 1 (nº 17) 1

Annex J: Stakeholder Workshop Presentation

Following is the Stakeholder Workshop presentation in English and Portuguese:

- Angola Health System Assessment: Preliminary Findings and Options
- Avaliação do Sistema de Saúde de Angola: Apresentação dos resultados preliminaries e das opções para intervenção

Avaliação do Sistema de Saúde de Angola

Apresentação dos resultados preliminares e das opções para intervenção

19 de Agosto de 2005

Catherine Connor, PHRplus
Ya-Shin Lin, QAP
Yogesh Rajkotia, USAID/GH/HIDN
Paula Figueiredo, MD, CONSAÚDE

Antecedentes/ Justificação

- Desenvolvimento da nova estratégia de apoio ao sector da saúde pela Missão da USAID em Angola , que inclui a componente de fortalecimento do sistema de saúde.
- Realização pela equipa , de uma breve análise do actual sistema de saúde para identificar as possíveis opções de intervenção , com vista ao fortalecimento do sistema de saúde – de modo global e não apenas para a missão da USAID.

Objectivos do workshop
o que iremos fazer hoje ?

- Partilhar os resultados preliminares e as potenciais areas identificadas para fortalecimento
- Obtenção de consenso sobre os resultados preliminares encontrados e sobre as opções de intervenção selecionadas (através da participação activa do grupo presente)
- Discutir as recomendações que poderao ser feitas a missão da USAID / Angola

Metodologia
Como foi desenvolvida a analise ?

- Visitas as estruturas sanitarias do sector público e privado nas Províncias do Huambo e Luanda (municipio do cacuaco)
- Revisão bibliográfica dos vários documentos existentes sobre o o sistema de saúde de Angola
- Encontros com os representantes de :

  MINSA – niveis nacional, provincial e municipal

  Governo Provincial e Municipal
  Doadores, sector privado , Grandes empresas ,
  ONGs nacionais e internacionais ,

Funções e Objectivos de um Sistema de Saude (OMS)

Funções

- Fornecimento e prestação de serviços
- Captação e alocação/ distribuição das finanças
- Liderança e supervisão
- Uso e distribuição de recursos humanos e fisicos

Objectivos

- Melhorar a prestação de serviços de saúde (preventiva e curativa) a todos os niveis de atenção
- Distribuição dos financiamentos de maneira equitativa
- Responder as necessidades das comunidades

Resultados Preliminares

Sistema Nacional de Saúde de Angola

Fonte: MINSA "Plano de Desenvolviment do Setor de Saude 2002-05"

MINSA

Regulamentação
Orientação
Planeamento
Avaliação
Inspecção

REDE NACIONAL DE PRESTAÇÃO DE CUIDADOS DE SAÚDE

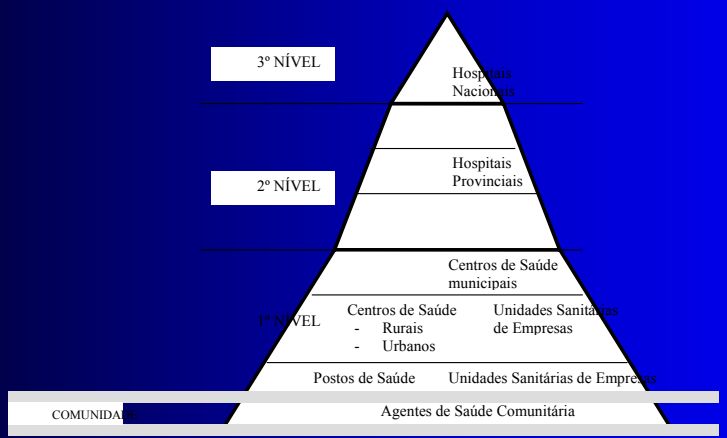
SERVIÇO NACIONAL DE SAÚDE

- INSTITUIÇÕES E SERVIÇOS OFICIAIS DEPENDENTES DO MINSA
- OUTRAS ENTIDADES PÚBLICAS

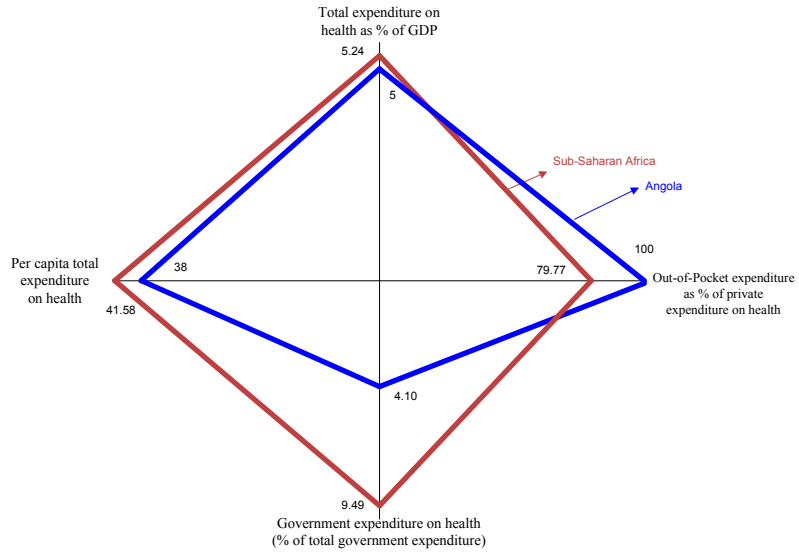
ENTIDADES PRIVADAS

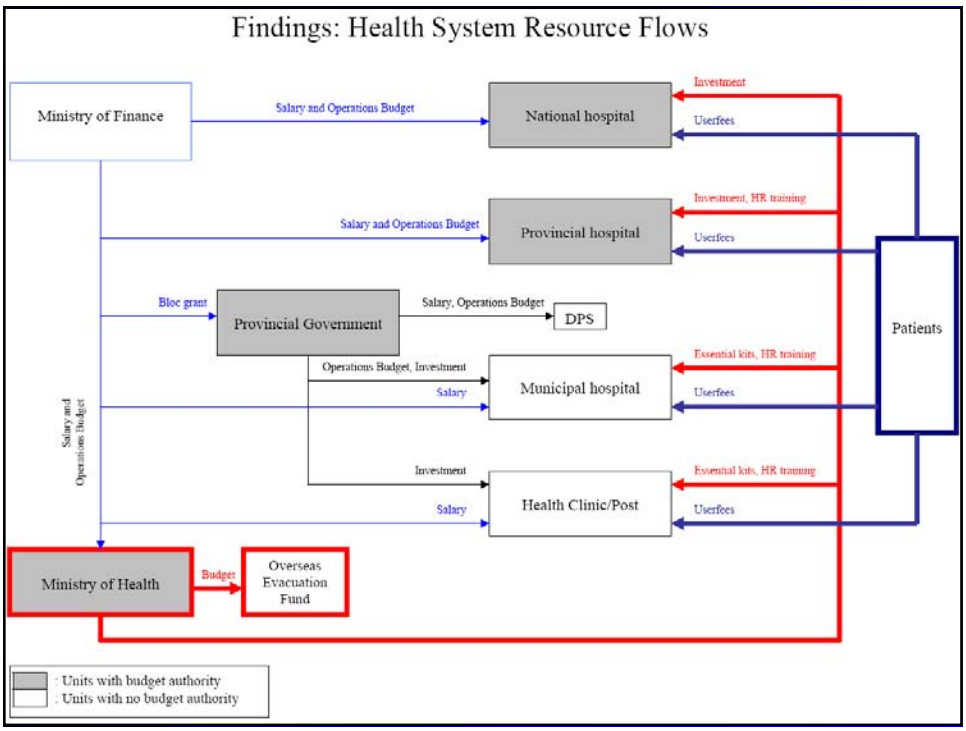
- LUCRATIVAS
- NÃO LUCRATIVAS
  - ONGs
  - IGREJAS

Serviço Nacional de Saúde



Finanças

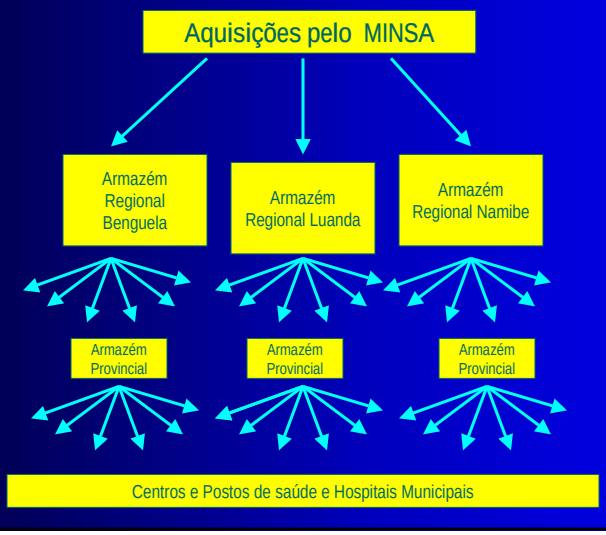

Total expenditure on health as % of GDP
5.24
5
Sub-Saharan Africa
Angola
100
Per capita total expenditure on health
38
79.77
Out-of-Pocket expenditure as % of private expenditure on health
41.58
4.10
9.49
Government expenditure on health (% of total government expenditure)


Findings: Health System Resource Flows
Ministry of Finance
Salary and Operations Budget
National hospital
Investment
Userfees
Investment, HR training
Salary and Operations Budget
Provincial hospital
Userfees
Bloc grant
Provincial Government
Salary, Operations Budget
DPS
Patients
Essential kits, HR training
Operations Budget, Investment
Salary
Municipal hospital
Userfees
Salary and Operations Budget
Investment
Essential kits, HR training
Salary
Health Clinic/Post
Userfees
Ministry of Health
Budget
Overseas Evacuation Fund
: Units with budget authority
: Units with no budget authority

Principais Desafios: Finanças

- Baixa percentagem no orçamento geral da saúde destinada a atenção primária (17% rede primária versus 40% para sector terciária)
- Não existe orçamento para os custos correntes das unidades sanitárias do 1º nível
- As altas " taxas "pagas pelos usuários resultam das cobranças nas consultas e da escassez de drogas
- A programação do orçamento é feita no sentido " topo – base" e não "base – topo "

Resultados da avaliação: Kits de Medicamentos essenciais



Resultados da avaliação: Kits de medicamentos essenciais

Pontos fortes:

- Os medicamentos Genéricos são comprados tendo em conta os preços do mercado internacional
- Existem concursos públicos para as aquisições programadas
- O uso racional das drogras está promovido a todos os níveis de prestação de serviços

Desafios:

- As aquisições feitas pelo MINSA geralmente não obedecem a programação temporaria , causando rupturas de stocks devido a financiamento irregular
- Pouco controle nos armazéns regionais, causando vulnerabilidade para desvios , perdas e má gestão dos medicamentos
- Insuficiência de viaturas para a distribuição
- Processos contratuais de aquisição pouco claros

Resultados da avaliação : Medicamentos não essenciais

- Medicamentos não essenciais são comprados a nível central , provincial e por alguns hospitais. Também podem ser adquiridos pelos Governos Provinciais .
- Não existem formulários , nem padronização das drogas , mecanismos para assegurar a qualidade dos fármacos , ou concursos competitivos
- Os fármacos não genéricos são a principal opção de compra ao invés dos genéricos
- A decisão da aquisição está muitas vezes relacionada com o incentivo financeiro e não do custo ou da especificidade

Resultados da avaliação : Prestação de serviços

- Baixa cobertura sanitária
- Defíce de equipamentos , material e kits de medicamentos
- Salários iguais aos da restante função pública
- Supervisão e treinamento verticalizado pelos programas nacionais
- Numero de tecnicos de nivel elementar e medio superior ao especializado
- Ascensão profissional não é de acordo com o desempenho e capacidade individual
- Dificuldades no sistema de referência da rede primária para terciária

Resultados da avaliação: Sistemas de Informação em saúde

- Sistema de notificação verticalizado
- Qualidade dos dados não assegurada
- Pouca capacidade para análise da informação
- O nível de atenção primária tem acesso limitado a retroinformação
- Não existe articulação entre a informação obtida e a planificação
- Sector privado e militar participam nos sistemas de informação em saúde?

Resultados da avaliação : Sector Privado

- Grandes empresas , ONGs , e grupos de igrejas (FBOs) desempenham um papel importante na prestação de serviços de saúde a população
- Taxa de utilização desconhecida (11% - 40%)
- Participam rotinamente no sistema de informação em saúde
- Em alguns casos , os preços practicados são semelhantes aos cobrados pelo sector público
- Exemplos positivos da aliança pública - privada :
  - ONG´s e participação da comunidade nos governos
  - Divina Providencia
  - Sonangol e VIH/SIDA, Esso e Malaria, Odebrecht , Coca cola , etc

Resultados da avaliação : Governação:

- Decisões tomadas do Topo para a Base e geralmente sem informação estatistica actualizada
- Existe Legislação , regulamentos e protocolos que não são correctamente implementados nas unidades sanitárias
- A estratégia e os planos do MINSA priorizam as acções de atenção ao nível primário, mas, a nível das US estas não são implementadas
- Há pouca participação da comunidade na área da saúde (responsabilidade e tomada de decisões)

Resultados da avaliação : Doadores

Mapeamento da resposta dos Doadores a Estratégia do MINSA

Reforço do Sistema de Saúde

Documento distribuido

PROPOSTAS DAS OPÇÕES DE INTERVENÇÃO

Critérios para opções

- Consistência com a estratégia do MINSA
- Consistência com a estratégia da Missão da USAID/Angola
- Sinergia com os investimentos dos outros Doadores
- Assistência técnica para a análise

Perguntas

Olhando as opcoes das estrategias listadas:

1) Quais seriam as 3 principais que voce recomendaria para a USAID?
2) Como sua organizacao poderia colaborar?
3) O que seria seu conselho para a USAID quando ela comecar a trabalhar em fortalecer o sistema de saude?

Planificação & Orçamento

Desafios

A Supervisão das US está dividida pelos programas nacionais

O processo de planificação e orçamento da saúde é feito de " cima para baixo" , pouco operacional e não orientado pela informação do sistema saúde

O financiamento dos custos correntes é escasso .Está pouco clara a responsabilidade destes

As comunidades locais têm pouco poder para melhorar a situação

Estratégias

Esclarecer a comunidade e os profissionais envolvidos (ex: DPS) sobre como é feito o processo do orçamento e como os fundos são libertados e usados

Trabalhar com o governo local (DPS/DMS) para usar os dados na preparacao dos planos e orcamento.

A inserção dos custos correntes no orçamento

Criar referência para o modelo de serviços de saúde com qualidade , iniciar a planificação e orçamento de acordo com as necessidades

Identificar fontes de financiamento para alcançar e manter a qualidade

Resultados

Planos operacionais e orçamentos direcionados a serviços públicos de saúde com qualidade elaborados pelos Governos locais e profissionais da saúde

Aumento do orçamento para os serviços públicos de saúde

MEDICAMENTOS: Kits de medicamentos essenciais

Desafios

Pouca capacidade para o processo de aquisições a nível do MINSA

MINSA sem capacidade de pagamento após a entrega

Os armazéns regionais não são bem administrados gerando perdas e má gestão dos medicamentos

Insufeciência de meios de transporte para distribuição dos medicamentos

Pouca segurança a nível dos armazéns provínciais

Estratégias

Aumentar a capacidade técnica do MINSA para a planificação (DPS e DSM)

Decentralizar os processos de entrega / distribuição e assegurar fundos para a distribuição a nível das províncias

Trabalhar com os orçamentos do MINSA e ou Governos Provínciais de modo a aumentar o investimento para armazenagem e trasnportes

Resultados

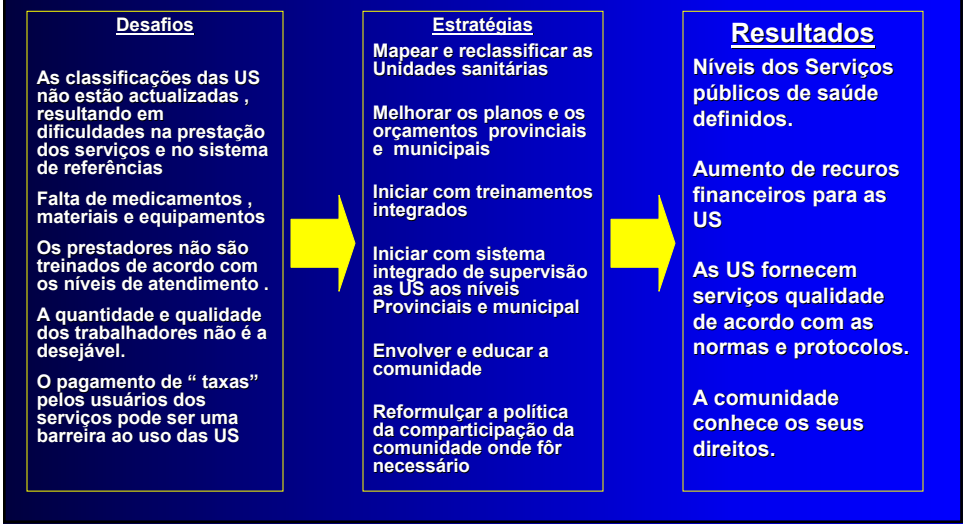
Fluxo regular de stocks nos 3 armazéns de distribuição regional

Capacidade de fornecimento fortalecida para assegurar a distribuição

Menor vulnerabilidade a perdas

Unidades sanitárias sem ruptura de medicamentos

Prestação de Serviços



Parceria Pública -Privada

Resultados orientados : Nível Central

- Melhorar a distribuição de recursos entre os diferentes níveis de atenção em saúde
- Assegurar que as normas e orientações dos Programas Nacionais sejam implementadas a todos os níveis
- Explorar a capacidade do sector privado para estes contribuirem com as prioridades do plano estratégico da saúde
- Fortalecer a capacidade institucional para a gestão do sistema de aquisições dos kits de medicamentos essenciais

Resultados orientados : Provincial

- Melhorar a alocação de recursos ao nível municipal
- Assegurar que os medicamentos essenciais sejam entregues as unidades de saúde , com segurança , em quantidade necessária e de forma regular
- Desenvolver mecanismos para a implementação e manutenção dos padrões de qualidade
- Integrar o sistema de informação em saúde no processo de planificação , programação financeira , financiamentro e manutenção da qualidade dos serviços públicos de saúde

Resultados orientados : Municipal

- Assegurar que o sistema público de saúde tenha os medicamentos e equipamentos necessários para fornecer serviços de qualidade
- Criar um modelo de prestação de serviços básicos a população com qualidade e a baixo custo
- Assegurar que os profissionais de saúde dos serviços públicos tenham o treinamento necessário para fornecer serviços de alto nível de qualidade
- Clarificar os procedimentos necessários para o financiamento de serviços de qualidade
- Trabalhar no processo de planificação e programação financeira a nível da administração municipal
- Desenvolver competências comunitárias para monitorar e influenciar as actividades sanitárias

Paradigma "Como" trabalhar

- Angolanos lideram a implementação e o nosso papel é o de providenciar assistência técnica
- Enfoque no modelo de " formação em serviço"
- Maior atenção na melhoria da qualidade de serviços com vista ao aumento da utilização pelos utentes
- Trabalhar a nível comunitário – onde os serviços são prestados as familias
- Isto ajudará a identificar os problemas a equacionar pelos níveis de decisão (políticas)

OBRIGADO

Angola Heath System Assessment

Preliminary Findings and Options

Assessment Team Debriefing at USAID
August 18, 2005

Catherine Connor, PHRplus
Paula Figueiredo, MD, ConSaude
Ya-Shin Lin, QAP
Yogesh Rajkotia, USAID/GH/HIDN

Background

- USAID is developing a new strategy for its support to the health sector in Angola that may include a component to strengthen the health system.
- The team conducted a rapid assessment of the health system to identify options for health system strengthening – in general (not just USAID).

What will we do today?

- Share preliminary findings
- Discuss a potential menu of options

How did we do the assessment?

- Visited public and private health facilities in Huambo, Cuacaco and Luanda
- Reviewed the extensive documents written about the health sector
- Met with representatives from:

  MINSA – national, provincial and municipal

  Donors Private Providers Large corporations
  International and National NGO's
  Provincial and Municipal government

Functions and Objectives of a Health System

What does the system do?

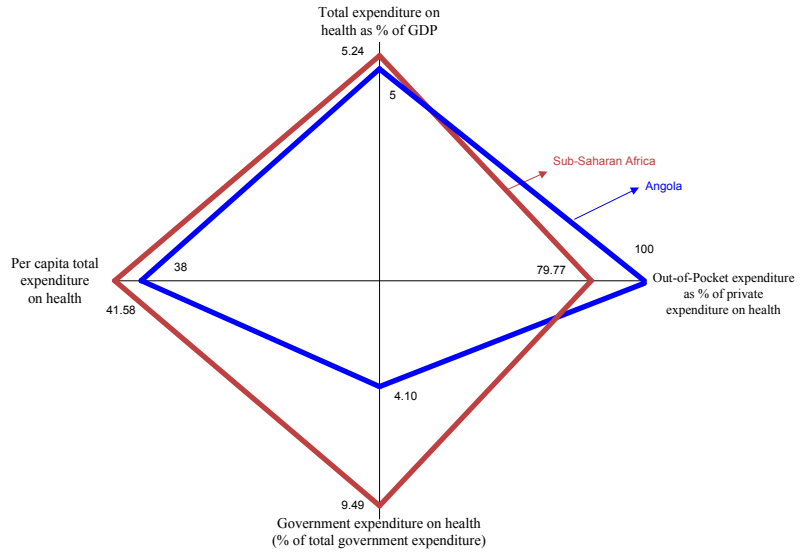
- Delivers Services
- Collects and allocates finances
- Provides supervision and leadership
- Uses human and physical resources

What does it seek to accomplish?

- Improve Health
- Make financing fair
- Be responsive to community needs

Preliminary Findings

Health Systems Findings: Finance



National Health System of Angola

MOH

Regulation
Guidance
Planning
Evaluation
Inspection

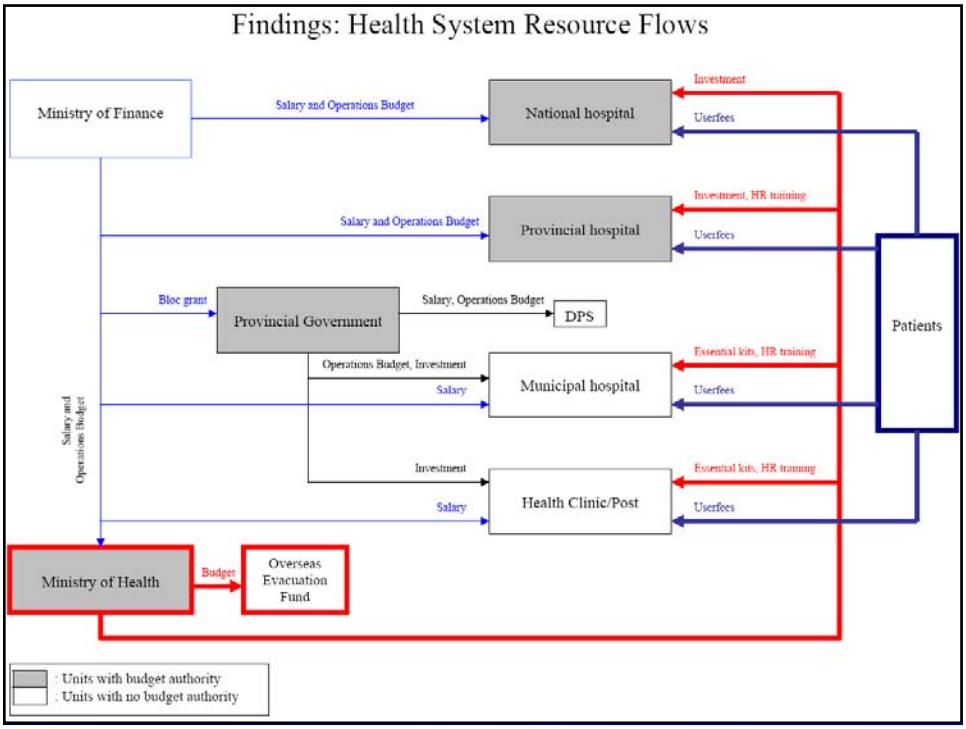
National network of provision of healthcare

National Health Service

- Health institutions dependant on MOH
- Other public health institutions

Private institutions

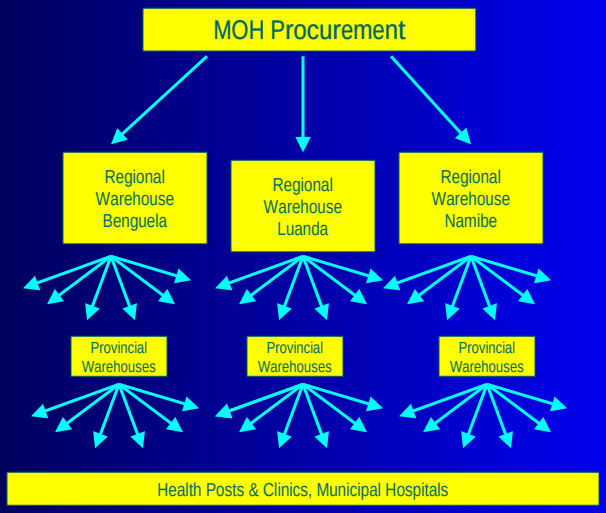
- For-Profit
- Not-for-Profit
  - NGOs
  - Churches



Key Challenges: Finance

- Low budget allocation to primary health care (17% primary vs. 40% tertiary)
- No budget for recurrent costs at primary care level
- High “user-fees” stemming from consultation charges and drug/supply shortages
- Budget process is “top-down”, rather than “bottom-up”

Health System Findings: Essential Drug Kits



Health Systems Findings: Essential Drugs Kits

Strengths:

- Generic drugs always purchased, on par with int'l prices
- Competitive tender always sought for non-emergency procurement
- Rational use promoted at all relevant levels of delivery

Challenges:

- MOH procurements untimely, leading to stock-outs
- Little government control over regional warehouses: vulnerable to theft and mismanagement
- Not enough trucks for distribution

Health Systems Findings: Non-essential drugs

- Non-essential drugs purchased by central, provincial, and some municipal hospitals. Also purchased by provincial governments.
- No formulary, selection standards, QA, or competitive bidding
- Branded products often favored over non-branded
- Selection vulnerable to financial incentives rather than cost or appropriateness

Health System Findings: Service Delivery

- Low population coverage
- Lack of supplies, equipment and drug kits
- Salaries on par with other public sector jobs
- Supervision
  - Inadequate management supervision
  - Vertical oversight and training by national programs
- Provincial nursing schools crowded and use outdated curricula
- Promotion not performance based
- Poor referral between primary and hospital care

Health System Findings: Health Information Systems

- Vertical notification system
- Data quality uncertain
- Low capacity for data analysis
- Program emphasis on timeliness
- Limited feedback to primary care level
- Disconnect between information and planning
- Private and military sectors participating in HIS?

Health System Findings: Private Sector

- Large employers, NGOs, and church groups (FBOs) are fulfilling a significant role in health service delivery
- Utilization unknown (11% to 40%)
- They participate in the routine HIS
- Prices are close to fees charged by public sector facilities in some places
- Promising examples of public-private partnership:
  - NGOs and community participation in government
  - Divina Providencia
  - Sonogal and HIV/AIDS, Esso and Malaria

Health System Findings: Governance

- Top-to-bottom authority and decision-making, often without data
- Laws, regulations, protocols exist, but not fully implemented in health units
- MINSA strategy and plans emphasize public and primary health, but not fully implemented in the health units
- Community accountability and participation in health is weak

Health System Findings: Donors

Map of MINSA Strategies and Donor Inputs for Health System Strengthening

See Handout

Preliminary Options

Criteria for options

- Technical analysis from assessment
- Consistent with Mission Strategy
  - Integration across the 3 S.O.s and across levels (national, provincial, municipal, community)
  - Gender as a cross-cutting theme
  - Geographic focus in selected provinces
- Synergy with other donor investments
- MOH ownership

Planning & Budgeting

Challenges

Supervision of facilities is fragmented among several national programs

Health planning and budgeting is top-down, not operational and not data-based

Funding for recurrent costs is scarce, locus of responsibility is unclear

Local communities have little power to improve situation

Strategies

Clarify for officials & community how budgets are made and how funds flow

Work with local gov't officials to create budget process for recurrent costs

Referring to model of PHC quality, start planning/budgets for needed funds

Identify sources of funds to achieve, maintain quality

Results

Local govts & health officials produce operational plans and budgets for quality PHC services

Increased budget for PHC

Pharmaceuticals: Essential drug kits

Challenges

Weak procurement capacity at MOH

MOH unable to pay for all delivery

Regional warehouses not well controlled, increasing vulnerability to theft and mismanagement

Not enough trucks for regular transport

Provincial warehouses have weak security

Strategies

Provide TA at MOH level on procurement planning

Decentralize delivery process & ensure funds for provincial level delivery

Work with MOH budget and/or provincial gov't process to increase capital investment for warehouse & trucks

Results

Regular supply flow into 3 key regional warehouses

Strong delivery capacity to ensure distribution

Less vulnerable to theft

Clinics more frequently stocked with essential drugs

Service Delivery

Challenges	Strategies	Results
Levels of service not fully implemented, resulting in poor referral and inefficiencies	Map and restructure facilities	PHC service levels defined.
No medicines, supplies or equipment	Improve provincial/ municipal budgets and plans	Increased funding for facilities
Providers may not be trained for service level required.	Integrated training	Facilities meet standards and deliver care according to guidelines.
Staffing may not be appropriate.	Provincial/municipal integrated supervision of facilities	Community expects PHC that meets standards.
User fees may be financial barrier	Involve and educate community	
	Reform user fees where needed	

Public-Private Partnership

Challenges	Strategies	Results
Community not involved	Community representation on municipal councils	Community influence decisions about health
Health system not accountable to consumers	Grants to local NGOs for public health initiatives in communities	Local NGOs strengthened
Harnessing corporate resources and the private providers effectively for public health	Public health workers in NGO or religious clinics	Increased coverage of population for selected health initiatives
	Corporate inputs consistent with MINSA strategy	Additional resources to achieve bigger impact on public health goals
	Integration of private providers in national PH initiatives	

Results Sought: Central

- Develop strong and regular procurement capacity at MOH level for essential drug kits
- Improve allocation of resources among different levels of care
- Ensure norms and guidelines for central programs are implemented at all levels
- Harness private sector capacity to serve national health priorities

Results Sought: Provincial

- Improve resource allocation to municipal level
- Ensure essential medicines are delivered safely to all relevant centers, at appropriate levels, on a timely basis.
- Develop mechanisms for implementing and maintaining standards for quality PHC
- Integrate the health information system into the process for planning, budgeting, financing, and maintaining quality PHC services

Results Sought: Municipal

- Ensure PHC has the drugs and supplies it needs to provide high-quality care
- Create model PHC practices that deliver basic services at modest cost
- Ensure health staff at PHC have the training necessary to provide a high standard of care.
- Clarify the financing requirements for quality PHC
- Demonstrate a planning and budgeting process for PHC at the municipal government level
- Develop community voice to monitor and influence health services

Features of "how" to work

- Angolans lead the implementation - our role is to provide assistance
- Emphasis is on learning by doing
- Focus on improving quality of care to increase utilization
- Work at the local level - where services are delivered to the community
- This will help to identify issues that need be addressed at a policy level


Thank you