CAPACITY ASSESSEMENT OF THE MINISTRY OF HEALTH OF THE REPUBLIC OF ANGOLA

June 2006

João Carlos Blasques de Oliveira M.D.

CONTENTS

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ASDI	Agencia Sueca para o Desenvolvimento Internacional (Swedish Internacional Development Agency)
CFR	Case Fatality Ratio
DNRH	Direccão Nacional de Recursos Humanos (National Directorate of Human Resources)
DNSP	Direccão Nacional de Salde Publica (National Directorate of Public Health)
DNME	Direccão Nacional de Medicamentos e Equipamentos (National Directorate of Drugs and Equipment)
DPS	Directo Provincial de Saúde (Provincial Health Directorate)
DFID	Department for International Development (U.K.)
EU	European Union
ETPS	Escola Tecnico Profissional de Saúde (Mid-level Nurse and Para-medical School)
ETS	Escola Técnica de Salde (only trains basic nurses)
GOA	Government of Angola
GEPE	Gabinete de Estudos Plano e Estatistica (MOH Cabinet of Planning Studies and Statistics)
GEPE/SC	Gabinete do Plano/Sector de Construção (MOH Infrastruture Sector)
HIV	Human Immunodeficiency Virus
HMIS/HIS	Health Management Information system or health information System
IMS	Instituto Medio de Saúde (Nurse Schools for registered nurses)
IDP	Internallly Displaced People
IUD	Intra Uterine Device
ISE	Instituto Superior de Enfermagem
MICS	Multiple Indicator Cluster Survey
MINARS	Ministry of Social Action and Reintegration
MOH	Ministry of Health
MOF	Ministry of Finance
NGO	Non-governmental Organization
OCHA	Organization for Coordination of Humanitarian Aide
ORS	Oral Rehydration Salt
PASS	Projecto de Apoio ao Sector da Saúde (Health Sector Support Project – European Union
PNLS	Programa Nacional de Luta contra o Sida (National AIDS Control Program)
PNME	Programa Nacional de Medicamentos Esenciáis (Essential Drug Program)
PCRRP	Post Conflict Rehabilitation and Reconstruction Program
PHC	Primary Health Care
PHCT	Primary Health Care Team
PHR	Partners for Health Reform
SMS	Secção Municipal de Saúde (Municipal Health Section)
STI	Sexually-transmitted Infection
TB	Tuberculosis
UNDP	United Nations Development Program
UNICEF	United Nations Children Fund
UNFPA	United Nations Family Planning Agency
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

WHO	World Health Organization

Executive Summary

The following table summarizes the strengths and weaknesses in the capacity of the health sector in Angola. A more detailed assessment is presented afterwards.

Strength and Weakness of the Health Sector in Angola and Opportunities.

Health Functions	Strengths	Weakness	Opportunities
Service provision	The MOH objective is to develop primary health care approaches and programs that provide preventive services to the population – such as EPI and maternal health services. The sector has the capacity to develop technical norms and guidelines for health programs and standard case management procedures for disease control programs. There are sound strategic plans for the major diseases and vulnerable groups	Excessive verticalization of disease control programs. Difficulty to implement and supervise the implementation of the strategic plan. Weakness of the health information system, including the disease surveillance system, which is not used for management purposes at all levels. The municipal level receives little feedback from information they produce. Health system and health facility management and planning is of limited quality due to lack of norms and trained personnel	Ensuring that at provincial and municipal level integration of programs is a reality, and creating integration mechanisms at the national level. HMIS including epidemiological surveillance is receiving support from partners. There is a need to train and develop human resources capacity in health statistics and in health system management and planning
Health system financing	Recent increase in the level of financing of the sector as % of GDP Decentralization of budget funds to the provinces and certain hospitals. Analysis of user fees. Capacity to mobilize funds from donors	Despite the increasing funding, the MOH does not attend to the needs of the majority of population. Too much funds go to hospitals compared to PHC services, Limited capacity in terms of management and budgeting.	The MOH with support of international partners is improving the participation of provinces in definition of budget and its link to the health plan. Revision of user fees.
Resource generation	Existence of Human resources development plan. There is a process to improve the quality of	Quality of training is uneven across the country and curricula for training of some category of nurses need further revision.	Need to define a human resources policy to improve supply of services. This may include the need for new health staff categories.

	training schools in the country through an accreditation process. There is a new National Drug Policy in process to be approved, Basic procurement procedures and tender documents exist. There is a huge effort on health facilities rehabilitation and equipment all over the country with support of international donors mainly China	The number of nurses (for example midwifes and pediatric nurses) and doctors are not enough for country needs. The acquisition of drugs and medical equipment as well as the overall logistical system including the procurement process is inefficient and prone to leakages. Stock-outs of drugs are frequent. There is no clear process to coordinate the rehabilitation of infrastructure financed from different sources. There is a risk of duplication and to respond to the regulation of the ministry. It is not clear how all new and rehabilitated health facilities will be staffed and maintained.	Training of health promoters should be resumed, under a new framework to be defined. The Ministry of Education is prepared to open new medical schools. New types of incentives to be developed to encourage health professional to move to the provinces and municipalities. New drug policy needs rapid approval and regulation. Support to the MOH to improve its forecasting, and procurement process through training and technical assistance. Support to help provinces and the MOH improve the coordinating capacity in planning the health infrastructure.
Stewardship	There is a political commitment to ensure health services for all. There is an ongoing effort to develop a National Health Plan through a participatory approach.	For years the sector was neglected in terms of political and financial support. Lack of a comprehensive and detailed health policy document. Laws can stay without regulation for years. The capacity to implement and enforce regulations is often limited. Low efficacy of the sector	There is room to improve stewardship, the one function providing the guidance and the normative and governance principles underpinning all other functions. Support to the design and implementation of a National Health Plan and involvement of provinces in the planning exercise.

		in consistently setting the rules of the game and monitoring service delivery	
Environment	The end of the war creates the possibility to expand heath care. The country has a huge economical potential in the future. There is a decentralization process at administrative and budget levels	The increased mobility of the population may cause imbalances between supply and demand for health services. It may require innovative approaches to service provision. The lack of coordination in the decentralization process has weakened the role of the MOH in managing the system. Decision making in the current coalition government requires more consultation for the reconciliation of different points of view, which may result in delays in the implementation processes.	Mobile service provision could complement the expanding health facility network. The decentralization process needs to be closely supervised and nurtured. The capacity of the structures to be decentralized needs to be strengthened. After the next elections, the government will have an opportunity to improve health policy and develop new strategies.

Introduction. The World Bank commissioned a capacity assessment study of the Ministry of Health (MOH) that was undertaken in March 2006. The terms of reference covered the following areas:

1. Identify the existing analytical work being done by other donors in the health field and summarize their terms of reference and main conclusions;
2. Assess the MOH capacity to implement health policies and strategies adopted by the government;
3. Assess the MOH capacity to implement projects financed by the Bank, the Global fund, EU and others focusing the analysis on the MOH capacity for policy formulation, mobilization of funds, and program implementation;
4. Assess the capacity at central, provincial and municipal level in (i) program management, (ii) service delivery, including the number and distribution of staff;
5. Analyze the decision making process and the incentives for decision making including how much the system is centralized or decentralized;
6. Analyze the existing stock of health professionals including the MOH and military, identifying key constraints and gaps in capacity, government plans to increase capacity; existing training institutions and their capacity to produce new professionals and follow-up training;
7. Propose options for short term and long-term interventions including training managers, training of doctors and nurses, recruitment, on-job-training, review of curricula and other;
8. Make cost estimates of short term capacity building interventions that could be financed by the Bank and other donors; and
9. Identify future work that may be needed to undertake deeper or follow-up analysis.

Methodology. The information was gathered through interviews with key staff in the MOH, Ministry of Defense, the University, and with the main stakeholders namely WHO, UNICEF, UNFPA, UNDP, the Global FUND, and USAID.

A review of the existing documents and reports on the health sector in Angola, as well as the most recent health sector appraisals and financing studies, helped in the analysis. These include the recent studies on capacity assessment of the health sector done by USAID, Global Fund/UNDP, and the EU–PASS project. The results of the work are also based on the previous experience of the consultant with the country and the MOH.

As work was carried out during only 10 days and by one consultant only, it was not possible to undertake an in-depth analysis or to visit locations outside the capital and the MOH.

General Country Profile. Angola, with more then 13 million inhabitants and an area of more the 1.2 million km², is a sparsely populated country. It has a young population, with about 50 percent under 15 years old, and 93 percent under the age of 50. Its total fertility remains high (7 in 2001). According to the Human Development Index, the country is in the 162nd place among 173 countries.

The prolonged armed conflict has prompted massive movements of population and produced about 4 million internally displaced people (IDPs), most of whom have found refuge in the costal provinces. Despite almost four years of peace there are still refugees and IDPs who are very poor, and it is still difficulty to reach some areas of the country.

Living conditions are still inadequate for the majority of the population. One third of the population is concentrated in three big cities. Poor water and sanitation increases the risk of ill health as demonstrated by the on-going cholera outbreak that resulted in more than 3000 cases by March 2006, with a case fatality rate of 4 percent.

Selected Health Indicators

Indicator	Angola	Sub-Saharan Average	Source
Total Population (2003)	13.5 million	15.0 million	WDI
Population Growth Rate (2003)	3.0%	2.1%	WDI
Rural Population (2003)	63.8%	61.8%	WDI
Life expectancy at birth (2003)	40 years	49 years	WDI
Fertility Rate (2002)	7.0	5.0	WDI
Infant Mortality Rate (per 1000 live births - 2000)	154	92	WDI
Maternal Mortality Ratio (per 100,000 live births)	1,700	914	WDI
Contraceptive Prevalence/100,000 (2003)	6.0	22.9	WDI
GDP/Capita US$D	975	1,073	WDI

Health Status and Vital Statistics. The health status of the Angolan population is one of the worst in the world. The 2003 maternal mortality ratio is reported by WHO at 1,700, compared to 600 in 1992. The under-five mortality rate is estimated at 250 per 1000 live births, and the infant mortality rate at 150 per 1,000 live births (UNICEF MICS II). For infants, the main causes of death are malaria, diarrhea, respiratory infections, anemia, measles, and in certain areas, malnutrition

Like a number of Sub-Saharan countries, Angola has not gone through the demographic transition. The MICS points to a total fertility rate of 7.0, with no significant difference between rural and urban populations. More worrisome is the fact that 27 percent of adolescents (aged 15-19) were mothers already and, in the sub-group of 18-19 years old it was as much as 33 percent. Women with secondary level of instruction tend to have lower fertility rates, around 5.2.

The use of contraceptives is very low at 6 percent, and only 4.5 percent of women use modern methods. The highest use of contraceptives is in Luanda with 15 percent and the central provinces with 10 percent. The pill is the most used contraceptive (34%), followed by Depo-Provera injections (23%), abstinence (18%), and IUD (6%). This

situation has negative implications in terms of reproductive health and maternal mortality.

The main causes of death for women are malaria, hemorrhage, eclampsia, abortion complications and prolonged labor. These causes are commonly associated to poverty and to the lack of access to adequate reproductive health services that are neither expensive, nor technically demanding. For example, in Malanje province, increased access and limited training provided in the provincial capital, helped to reduce the MMR from 3007 /100,000 in 2000 to 1085/100,000 in 2003.[1]

The nutritional status of Angolans remains poor. The MICS II indicates that 45 percent of children suffer from chronic malnutrition, an improvement over 1996 when 53 percent of children were malnourished. Angola has a high level of stunting and this will have enormous social and economic implications in the future. With 6 percent prevalence, the severity of wasting among Angolan children can be considered medium according to WHO threshold levels. More recent evidence shows that, from 2002 until the end of 2003, the health status has improved all over the country, and severe malnutrition is only expected in some areas.

Epidemiological Situation. Angola's epidemiological profile is characterized by a high burden of disease related to nutritional deficiencies, and infectious and parasitic diseases, including malaria, tuberculosis, and HIV/AIDS.

The epidemiological surveillance system is poor. In recent years, with support from WHO and UNICEF a network of sentinel sites, based on a system of radio transmission, was established, and covers almost all the provinces. In 2001, the most common causes of visits to health facilities were malaria, acute respiratory infections, diarrhea, and typhoid fever. Among transmissible diseases, tuberculosis was the sixth cause for visits to health care facilities, and measles the tenth. Malaria and diarrhea were the most important causes of death, followed by tuberculosis and respiratory infections.

Malaria alone accounts for more than 60 percent of all outpatient visits and death by transmissible diseases reported in 2001. According to the National Malaria Control Program, every Angolan typically experiences 3-5 malaria episodes per year. The MICS II, using prevalence of fever as a proxy for malaria, reports that 25 percent of the children had fever in the previous two weeks. Only 10 percent of the population uses bed nets.

A small number of diseases, namely malaria, acute diarrhea, acute respiratory infections, measles and neonatal tetanus, are directly responsible for 60 percent of child deaths. Yet it is well known that it is easy to prevent or treat these problems at primary health care facilities, and through improved practices and care at the household level.

Diarrhea has a prevalence of 25 percent among the under-five year olds (MICS II), but only 7 percent of these cases were treated with rehydration fluids and continued feeding. The use of oral rehydration salt (ORS) was only 40 percent in these cases. Measles was

[1] *Malange DPS- 2003 Annual Report- Draft*

the fifth cause of death by infectious diseases. A recent measles immunization campaign was conducted by the government with support from UNICEF. It was successful and covered 93 percent of the 7.3 million target population of children between 6 month and 14 years old. During the last five years there have been outbreaks of meningitis and cholera in Luanda and some southern and central provinces that put an added burden on an already weakened health system.

One disease that is highly prevalent in the northern areas of the country is trypanosomiasis (sleeping sickness). There is a specialized autonomous institute set up to control the disease and actions related to this disease should be included in any basic health care intervention in the endemic areas.

Tuberculosis prevalence is increasing. Studies from 1990 estimated the annual infection risk to be 1.2-1.9 and the incidence to be of 120 cases per 100,000 inhabitants. Data from the TB program for 2001 (MOH TB Program Annual Report) shows more than 21,000 TB patients. Since 1996, the country has adopted the DOTS strategy for treatment. At the present time, it covers 44 of 163 municipalities in the country and about than 43 percent of the population.

The AIDS Epidemic. AIDS is a significant health problem in Angola. Surveys done by the National Institute of Health and the Italian Cooperation show a trend of increasing prevalence in pregnant women especially in Luanda and among sex workers. A recent survey, supported by CDC-Atlanta, covered more provinces that the 2001 survey. It showed a prevalence of around 3.9 percent. There are disparities among prevalence rates in the provinces, and Cunene, Benguela, Cabinda and Luanda have already well established epidemics

The recently-created National Institute against AIDS is an autonomous organization with its own budget and management. It is currently revising the AIDS strategic plan and developing a new plan for a three-year period. It has also started to launch projects based on the strategic plan. The institute has insufficient qualified human resources at the central and provincial levels. Its functions should be aligned with the administrative and budgeting decentralization that exists in the country.

The Global Fund and the World Bank financing for HIV/AIDS have provided significant resources to the sector and helped place the control of the epidemic high on the government's agenda.

There are clear signs that the epidemic is well established in the population in certain areas such as in Luanda and especially in the southern province of Cunene where the prevalence rate is above 10 percent. A survey done in 2001 showed that almost 9 percent of pregnant women in the main maternity ward in Luanda hospital were HIV positive. The numbers are even worse in the case of sexually-transmitted infections and specifically on syphilis. Recent studies done by GOAL (an Irish NGO) and IPMP in 2001 and 2002 respectively, show that at VCT clinics, 80.6 percent of the attendees were

positive to syphilis. TB and HIV/AIDS are closely associated: 19 percent of TB cases in the main TB Hospital were HIV positive.

There is a low level of knowledge about the epidemic and about the disease that contributes to people maintaining risky behaviors that continue the spread of the epidemic. Of significance is the high level of stigma associated with the disease: 31 percent of respondents to the GOAL survey believed that to stop the spread of the disease one should avoid social contacts with people living with AIDS.

The use of condoms is low, even among sex workers who are aware of the risks of contracting sexually-transmitted infections (STIs). According to the 2001 KAP survey done by Population Services International (PSI) in Luanda, only 43 percent of males and 40 percent of females aged 15-25 years used a condom in their last sexual encounter. The use of contraceptives is low (2.8%) and sexual life begins early for girls (13-15 years old). The most common ways of HIV transmission are heterosexual (55 percent of all cases registered by the National Aids Program), mother-to-child transmission (14%), and blood transfusion (8%).

Analytical Work by Other Partners. In the last 18 months, the Angolan health sector has been the object, of various studies, from different partners. Most of them point to capacity limitations in the sector. A summary of the terms of reference and objectives of these studies is presented below

1. **Study on Copayments.** Funded by the EU, the study aimed to evaluate the copayment scheme of health services in Angola, identifying strengths and weaknesses, and making recommendations to improve the efficiency, equity and the quality of public health services.

   The study had as specific objectives to: (i) estimate the amount and flow of funds originating from payment for services in the health system; (ii) evaluate the willingness and capacity to pay for these services; (iii) analyze the revenue management system including the description of the collection system and the decision making process related to the use of funds; and (iv) describe and analyze the exemption mechanisms.

   Two instruments were designed and used to collect the information from patients and from managers in five provinces where the EU/PASS project is operating. The main conclusions of this study are presented later in the report.

2. **Study on Service Delivery Costs.** The study aimed to respond to the need for the MOH to improve its planning capacity. The study intended to provide a picture of the actual costs of service provision in five provinces in Angola. By providing correct data on costs of service delivery, it would help managers prepare better budgets and improve planning.

   The specific objectives of this study were: (i) to help the MOH, the Ministry of Finance (MOF), and the Ministry of Planning improve resource allocation to

health facilities; (ii) help facility managers improve efficiency in using public resources; and (iii) develop and implement a costing methodology for the MOH.

The study used the year 2004 as reference. A total of 22 public facilities in 5 provinces were surveyed. Data were collected from interviews and reports and accounting registries in health facilities.

The study found that the unit cost of outpatient services in the health facilities surveyed in the five provinces was US$22 for the budgeted units (national and provincial hospitals) and US$8 for the dependent units (Municipal Hospitals and health centers). The mean cost per patient/day in the budgeted hospitals was US $32.9, and US$20.5 in the municipal hospitals. Cost recovery represented only 4.1 percent of total costs.

The study also stated that the acquisition of goods and services did not follow clear procedures, with the result that prices were often higher than the fair market price, which added significantly in the final costs of the health facilities.

The determinants of unit cost were mainly human resources in each cost center, and their low productivity. This was the result of the existence of too many non-professional health workers, poor or no regular evaluation of staff, and lack of basic inputs such as drugs or laboratory materials.

Finally the study concluded that there is inequity in the budget per capita allocated per province, associated to the limited capacity of provinces to negotiate the allocation of resources.

3. **Angola Health Sector Assessment.** A recent broad study on the health system was done by USAID, through Partners for Health Reform (PHRplus). The objectives of the evaluation were: (i) to assess the country's health system; (ii) to help improve the impact of USAID's health projects; (iii) to help conceptualize key issues; (iv) to increase the use of health system interventions in technical program interventions; and (v) to improve the role of USAID's Health Systems Division.

4. **Institutional Diagnosis of the MOH.** This study was undertaken by consultants contracted by UNDP for the Global Fund. It consisted of a diagnosis of the institutional capacity of the MOH. It would facilitate preparation of an institutional strengthening plan for the MOH so as to increase the Ministry's capacity to manage future Global Fund grants.

   The study was developed in a participatory manner and focused on: (i) identifying the institutional capacity required to manage programs and projects; (ii) analyzing the monitoring and evaluation capacity of the MOH; and (iii) assessing the budgeting and financial management capacity of the MOH. The study involved the Department of Human Resources (DNRH), the TB and Leprosy Control

Program, the Pharmaceuticals and Equipment Department (DNME) and the Planning Department.

The study recommends: (i) strengthening human resources in the areas of leadership and participatory management; and (ii) improving the administrative flows and processes.

Organization of the Health System. The Angolan health system consists primarily of a public system under the oversight of the MOH. The network of facilities covers all the provinces and is organized in three tiers: (i) the primary level with health posts, health centers and municipal hospitals; (ii) the secondary level with provincial hospitals providing specialized assistance; and (iii) a national tertiary level with specialized hospitals. There is also a military health subsystem with a central hospital and some regional hospitals.

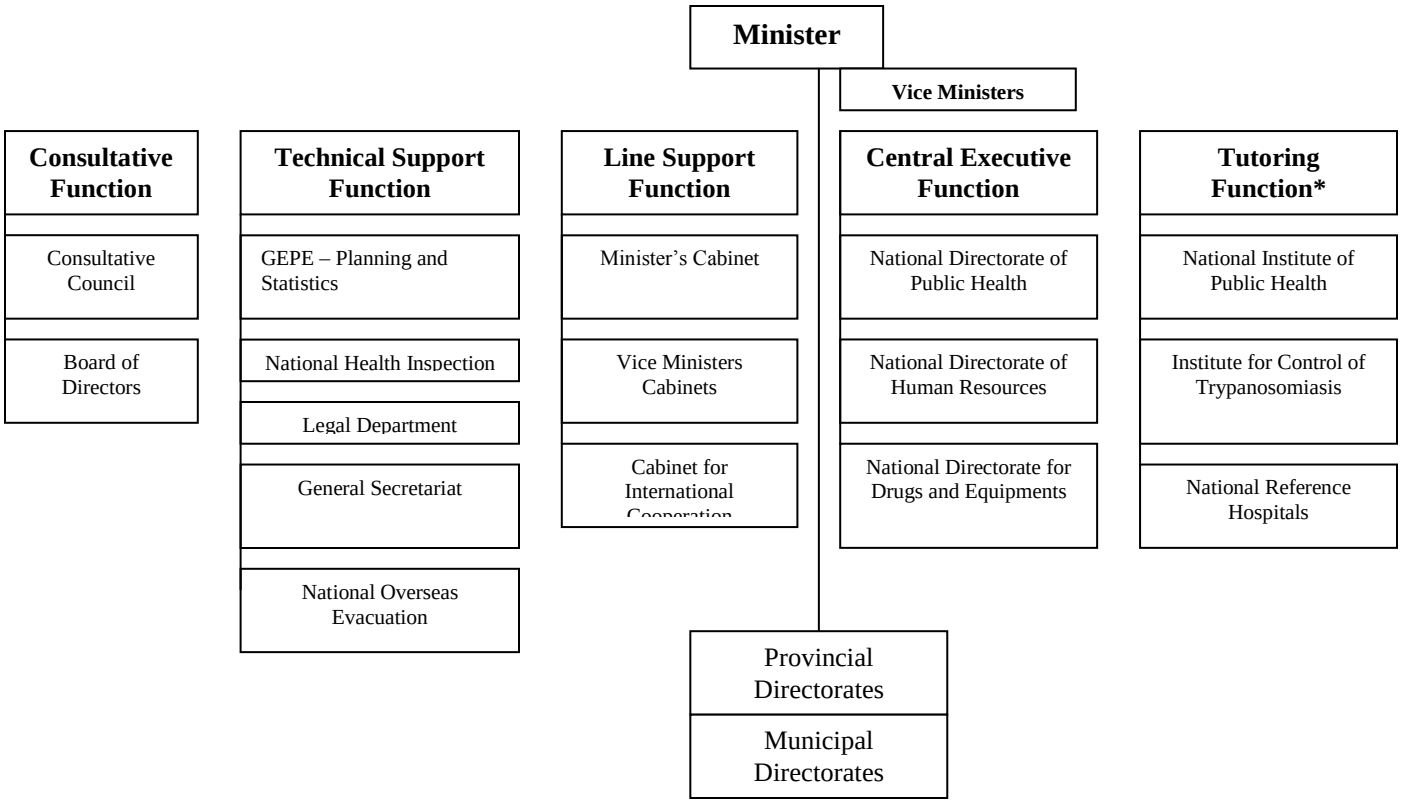
The organization chart of the Ministry of Health is presented on the next page.

The private sector is characterized by: (i) a small health network, limited to the oil production regions and serving mainly oil company workers and their families; (ii) an expanding network of not-for-profit NGO and church-controlled health facilities and systems; (iii) a for-profit health system that provides services in the main urban areas with variable levels of quality; and (iv) the traditional health sector (traditional healers, traditional birth attendants etc.) that is not regulated but widely used both in rural and urban areas.

A 1992 law loosely regulates the health system. The "Regulamento das Unidades Sanitarias" (Health Facility Regulation) defines and characterizes the health facility network at all levels, introduces the concept of health area (municipality), and defines the functions and minimum package of services and human resources required by each service level. So far the government has not disseminated the "regulamento" at the provincial level.

The health sector has suffered tremendously from the long civil war that has resulted in more than 70 percent the health facility network being destroyed. In some provinces it was more than 90 percent. As a result, more than 60 percent of the population has poor access to health care. Even after almost four years of peace, people still have to walk more than one hour to reach a health facility on average.

Ministry of Health Organizational Chart (2002)

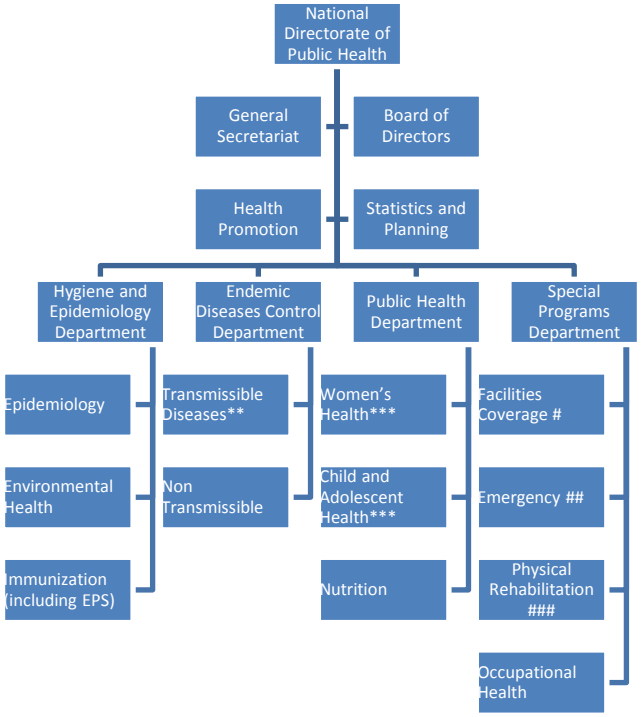


Notes: * The so-called "Orgaos Tutelados" have budgeting, planning, and managerial autonomy and are supposed to search for additional financing to complement what they receive from the state budget. In the budget system they are called Budgeted Units (Unidades Orcamentadas).

As the National Institute to Fight Aids has been created recently, it does not appear in the above chart. It should logically be under the protected function (Orgaos Tutelados) category.

Given its importance, the National Directorate of Public Health (DNSP) is presented in more detail below.

Organizational Chart of the National Directorate of Public Health



Note:

** This Department of Transmissible Diseases covers the TB and Malaria Programs as well as shistosomiasis and onchocercosis

*** This department covers reproductive health, family planning, and IMCI

This department is in charge of defining the structure of the primary health care health facility network, producing supervision and functional norms and disseminating them. It has limited operational capacity.

This department responds to emergency situations such as natural disasters.

The Physical Rehabilitation Department attends to the needs of handicapped people in Angola and has programs specifically designed for that objective, operating with support from the International Red Cross

Health Facilities by type and operational status

Provinces	Health Facilities Status					
	Hospitals		Health Centers		Health Posts	
	Operational	Non Operational	Operational	Non Operational	Operational	Non Operational
Bengo	5	1	2	1	30	57
Benguela	10	0	25	0	65	2
Bié	4	0	7	0	35	0
Cabinda	4	0	11	0	79	26
Cunene	2	0	8	0	52	0
Huambo	7	1	36	0	44	86
Huíla	6	0	21	3	99	166
K. Kubango	8	3	4	0	15	3
Kwanza Norte	2	0	12	0	27	0
Kwanza Sul	5	4	18	4	108	60
Luanda	13	0	34	0	13	0
Lunda Norte	5	0	5	10	12	28
Lunda Sul	3	0	3	0	32	57
Malanje	10	1	18	2	50	48
Moxico	5	1	14	0	145	116
Namibe	2	0	6	0	33	0
Uíge	5	1	19	8	55	141
Zaire	4	0	6	0	32	0
Total	100	12	249	28	926	790

The government is making a significant effort to rebuild the network, through projects financed by China, the EU, the World Bank (health component of the EMRP), as well as government funds. A huge reconstruction effort is in place in all provinces to rebuild health facilities, municipal hospitals, and health centers. In Luanda, a provincial hospital of more than 100 beds was recently opened.

With only a young architect on a part-time basis, the Department of Planning has limited capacity to prepare investment plans and to follow-up, supervise and control all this reconstruction effort. At provincial level the situation is even worse. Because of this lack of capacity, it is not clear how all these hospitals and new health units will be staffed and equipped. In the case of the Chinese-funded reconstruction effort, it is coordinated

through a special unit of the Ministry of Planning. Overall, there is already some indication that the process is poorly supervised by the MOH and there are some inadequacies in the new buildings and equipment.

Health Information System (HIS). In the case of Angola, the health information system is located in two main areas. The specific epidemiological programs for disease control are managed by the National Directorate of Public Health (DNSP). Epidemiological data are collected by the programs and by the provinces and integrated at the central level in the Department of Hygiene and Epidemiology. Every quarter these data are provided to the Department of Planning that integrates the information in the general statistics year book.

Information on health services utilization is collected by national, provincial and municipal hospitals, health centers and health posts and sent every month to the central level. Up to 2005, the process was working well and the reports from the provinces were arriving with a two-week delay after the previous month. The situation, however, has deteriorated, and now the delay can reach 2-3 months. The collection of data on mortality in Luanda cemeteries, that helped to make a better assessment of mortality, was stopped more then two years ago.

Delays in data collection result in delays to produce the statistical year book, currently the best collection of data to support decision making and to help define strategies and programs. The year book is discussed and approved by the top management of the Ministry. A recent consultative council decided to add financial and budget information to the year book.

A major constraint of the HIS is the limited capacity of the MOH in statistics and epidemiology. The only person in the statistics department with higher education is the Head of Department who is currently finishing his graduate studies in computer sciences. The other five members of the department are medium-level health technicians. Recruiting new personnel is difficult because of the limitations in new public sector positions.

The HIS is one of the areas where significant improvement must be introduced. It is important for the MOH to review the HIS design. New investments in human resources and information technology would also have a significant impact. Without providing timely and good-quality information, it will be difficult for the MOH to monitor and evaluate the results of its policies and programs, and make the right decisions accordingly.

The health sector has no standard policy to collect population-based data on a regular basis. Some population-based studies related to health have been done by UNICEF (MICS), WHO, and international NGOs. In its last consultative meeting, the MOH decided to conduct community-based surveys on health services utilization, quality, epidemiology, knowledge and practices, and maternal mortality.

Development of Policies, Strategies and Action Plans. The government has prepared a sound policy framework, and has started to decentralize decision making and de-concentrate health service delivery. Nevertheless much remains to be done to: (i) adjust the institutional and legal framework to the new roles and responsibilities of the central, intermediary, and local levels; (ii) further decentralize decision making; and (iii) strengthen the capacity of the provinces and municipalities to manage resources. The MOH national departments, especially the ones linked to disease control, are organized by diseases and are supported vertically by donors. This has created various parallel management, logistics and information systems that are not integrated with the national departments. The supervision of these programs is not coordinated, and there is no benefit from economies of scale.

Planning was traditionally done through a top-down approach. Since 1998, the MOH has experimented with a participatory approach in preparing the annual budget and plans, through a larger involvement of the provinces. Recently PASS, the EU-funded health project helped the Planning Department conduct a large planning and budgeting exercise involving the provinces. However, in the provinces and even worse in the municipalities, the lack of human resources qualified in health management and planning limits the efficacy of a bottom–up approach, and may even result in a poor definition of needs and resources.

The capacity of the sector to monitor and evaluate programs is very weak at all levels. This results from the lack of trained personnel to plan, monitor, and supervise administrative and budgeting processes. Feedback, even related to the routine health information system, is almost non-existent. However, internationally-funded programs and projects are regularly evaluated externally, because of the requirements of the financing agencies.

At the end of the 1990s, provincial directors used to receive one month training on health management and planning in Israel (Galilee College) with support from the First Health Project of the World Bank. Limited training in health management and planning is currently provided to provincial health teams. In 2004, about 20 health professionals from national hospitals and provincial hospitals and departments received one year post-graduate training in hospital administration, provided by the National School of Public Health in Portugal. Some of these professionals, however, have moved, and the provinces no longer benefit from their capacity and skills. Six of them are in Angola working for NGOs, and the private and public sectors. Another six are working overseas.

In the future, the MOH must ensure that professionals who receive training can use their skills properly, for example through the building of health management teams, the design of provincial health plans, and the adoption of better management and budgeting practices. The recent collaboration between the MOH and PASS to prepare a national health plan is a positive step in that direction.

Government Financing and Budgeting. The national budget is managed by the Ministry of Finance using the Integrated State Financial System (SIGFE). The Ministry of Health at the central level is classified as a budget unit. It manages the budget of

dependent units such as the Pharmaceuticals and Equipment Department and the Public Health Department.

The Provincial Health Departments depend on the provincial governor's budget that is directly allocated by the MOF, with a budget line earmarked for salaries for each sector. The MOH has little or no power to decide the budget allocation for provincial health services (or of other decentralized budget units) and even less to influence the use of the funds.

Expenditures in the health sector have been increasing since 2000. Recently, based on a sample of five provinces, the PASS project estimated that the public expenditure for health in 2005 was US$40 per capita per year[2]. When other provinces are added, the average per capita spending may come down. Nonetheless it points to a relatively high level of spending compared to other Sub-Saharan countries, but not providing adequate results in health outcomes, an issue that will be addressed by the Bank in the Public Expenditure Review that started in June 2006.

In 2001, the sector spent almost US$13 million on drugs and US$16 million for the control of communicable diseases. It also spent a similar amount on overseas medical care. In 2003 the MOH received almost US$31 million in the PIP. Spending for recent years shows a similar pattern. In 2004 and 2005 the funds available to the sector increased significantly and almost doubled, mainly because Chinese funds for infrastructure rehabilitation started to be included in the budget in 2004.

For 2006, the sector has demanded, based on a participatory approach with the provinces, an estimated 11,752 million kwanzas for the central level (including national hospitals) which means a proposed increase of 56 percent over the previous year. Budget parameters were conservative.

There are huge differences in provincial health expenditures. Should the government increase the resources allocated to the sector, it should make a special effort to correct imbalances and distribute more resources to the less advantaged provinces. It should also ensure that primary health services receive a bigger share of the budget.

The MOH has limited capacity to manage funds (government budget as well as donor funds), as confirmed by the evaluation made by UNDP/Global Fund. With support from the EU and other partners, the MOH is trying to improve its capacity for budget preparation and management, and will link the budget to a plan of action prepared by the provinces. The MOH is currently preparing a National Conference on Health Financing to discuss different approaches on health financing in Angola. The result of the recent studies on copayment and costs in the health sector will be used as inputs.

There are four constraints to the budgeting process. The first is the delay in budget approval. By the end of April 2006, no budget had been approved for the sector, which

[2] Governo de Angola, Ministério das Finanças, Revisão do OGE para 2006

means at least a four-month delay since the fiscal year starts in January. This is a major constraint for the MOH and limits its ability to fund its operational plans.

The second is the cap defined by the MOF that allows for only a 10 percent variation in expenses, certainly insufficient if one considers that inflation alone for the first semester of 2005 was 11.3 percent (Angola National Bank).

The third constraint is that the program classification developed by the MOF (SIGFE) is not adapted to the real programmatic definition in the health sector. This limits the capacity of the MOF and MOH to monitor the performance of the sector, and notably to improve the management of the hospital system.

Finally, the health sector has a significant lack of information about costs of service production. This does not allow developing instruments for resource allocation, co-financing of costs, and eventually subcontracting of services.

Funding from International Donors. In 2000, the contribution of donors to the health sector budget was 24 percent of total health expenditures, with only 10 percent of their contributions directed to the central level. In some provinces -- Bié, Bengo, Huambo, Kuando-Kubango, Malanje, and Uige -- the donor contribution exceeded 50 percent of the provincial health expenditures.

The Chinese loan for infrastructure has benefited the sector broadly, and after recent funding from the Global Fund and the World Bank, the country may not need much more external funding for disease control programs. Because of is wealth in natural resources, Angola will be less dependent on international assistance in the medium term. However, in the short term the country will still need external financing and is willing to receive support from multilateral and bilateral partners.

The EU is one of the most important players. Besides its support to strengthen the health sector in five provinces, it is also supporting some areas of the central MOH namely pharmaceuticals, equipment, planning, and blood supply. It is currently preparing its new country assistance program that will include some interventions in the health sector.

NGOs operating in Angola no longer have access to emergency funds from the EU and the World Food Program. They now depend on their own funds and on country-specific grants to finance primary health care and community projects.

USAID will soon start an Essential Health Services Program of about US$ 9 million over four years, which will be implemented by an American NGO in collaboration with local provincial health structures. The program is intended to cover Luanda province including 10 municipalities, Kwanza Norte including 4 municipalities, and Lunda Norte with 3 municipalities. The project intends to strengthen the health system in these provinces, especially maternal and child health care.

User Fees. The National Health Service Law of 1992 includes co-payments as an additional source of financing for the health sector. Implementation of the system started in the mid 1990s, but it was regulated only in 2002. Health facilities use the revenue to reduce their dependence on provincial and municipal budgets, and use the funds to buy goods or small services. However, the process is not supervised and there are no clear guidelines and procedures to ensure the correct use and accountability on these funds.

The copayment study shows that user fee funds represent 4 percent of total costs and 22.7 percent of the cost of goods and services. For 19.8 percent of patients, users fee are felt as a constraint and a reason for not seeking care. For families, user fees can represent up to 19 percent of their monthly revenue. Only 39 percent of families were able to cover the health costs with their own money. Fifty one percent of patients who had the right to have exceptions did not receive them as a result of the MOH weak capacity to implement exemption policies. There are still a number of patients that have to pay bribes to access health services.

So far, the government has decided to maintain user fees. It does, however, understand the equity implications and remains open to possible adjustments in the future. Hospitals and health centers are especially keen to keep user fees.

Coordination with Donors, NGOs, and the Private Sector. The sector has improved its coordination with bilateral and multilateral partners, but coordination with civil society is still weak. At the end of the 1990s, a DFID project, implemented with support from WHO, tried to improve coordination with stakeholders, particularly NGOs, but that experience has not been sustained

The Country Coordination Mechanism (CCM) of the Global Fund could provide a forum for coordination, but utilization is mainly limited to Global Fund operations. There are various commissions integrating the bilateral, multilateral and NGO partners, mainly for disease control programs that duplicate each other and create inefficiencies.

Little is done by the MOH to coordinate actions with the private for-profit sector, except in terms of regulation. Some coordination is done with oil companies that provide health services to their workers.

Provincial Capacity and Decentralization. As a result of the decentralization started seven years ago by the MOF, Provincial Directorates of Health depend on provincial governments, and hence the MOH has limited power to control the planning and execution of resources. It can only define overall policy and provide some methodological guidance. In the case of vertical programs, it has more capacity for intervention.

Provinces have significant coordination and planning difficulties. Resources are not well planned and there are no defined coherent strategies even though clear and well accepted technical guidelines are available world wide, such as for the reduction of maternal and infant mortality.

Human Resources Development and Management. Human resources management suffers from leadership weaknesses and the lack of clear norms and regulations. The situation is more critical at provincial and municipal levels. The morale of health personnel is negatively affected by the low level of salaries, insufficient clarity on the career alternatives, poor conditions of facilities, and the lack of drugs and equipment.

According to the MOH, Angola has about 60,000 health workers including about 1,000 medical doctors. The situation of the health personnel compares poorly with countries of a similar income level and is compounded by geographical distribution problems: more than 80 percent of doctors are located in Luanda. There are no appropriate incentives to reward good performance.

Total Number of MOH Personnel in the MOH (no registry of other sectors)

Doctors	Nurses	TDT*	Hospitals Aids	Administration	Total
1,165	18,485	3,720	12,387	26,071	61,828

Source: DNRH 2005 - (Total number listed in the DNRH and includes personnel not yet introduced in the computer system)

Human Resources by Category and location - MOH only

	Doctors		Nurses		TDT*		Non-technical		
Province	Nationals & Foreigners	Nº/ 100000 inhab	Includes all categ.	Nº/ 1000 inhab	TDT*	Nº/ 1000 inhab	Hospital Aids	Admin.	Total
Bengo	32	1.10	390	1.10	47	0.13	30	894	1,393
Benguela	63	4.01	2,531	1.61	323	0.21	511	1,000	4,428
Bie	23	2.26	939	0.92	36	0.04	305	679	1,982
Cabinda	39	10.78	741	2.05	216	0.60	119	651	1,766
Cunene	22	4.90	474	1.06	25	0.06	85	218	824
Huambo	40	3.49	2,629	2.29	272	0.24	479	644	4,064
Huila	57	4.23	1,277	0.95	320	0.24	455	1,377	3,486
K.Kubango	13	2.53	364	0.71	8	0.02	45	276	706
Kwanza Norte	20	3.86	400	0.77	33	0.06	24	390	867
Kwanza Sul	49	4.34	1,128	1.00	81	0.07	26	94	1,378
Luanda	622	21.19	4,918	1.68	1,930	0.66	2,179	7,011	16,660
Lunda Norte	28	5.84	345	0.72	32	0.07	77	300	782
Lunda Sul	25	9.01	417	1.50	77	0.28	39	430	988
Malange	25	3.04	541	0.66	31	0.04	100	344	1,041
Moxico	19	4.30	698	1.58	78	0.18	46	21	862
Namibe	31	12.26	459	1.81	188	0.74	70	292	1,040
Uige	32	2.42	588	0.45	60	0.05	133	423	1,236
Zaire	25	8.78	136	0.48	29	0.10	60	147	397
Total	1165	7.65	18,975	1.25	3,786	0.25	4,783	15,191	43,900

Source DNRH 2004 - only includes the personnel that has already being integrated in the new computerized HR system

Note* : TDT (Diagnostic and Therapeutic technicians) includes laboratory technicians, radiologists, physiotherapists

During 2002, salaries increased (at the beginning of his/her career, a doctor can receive US$600-700 per month), but given the high cost of living in Angola, this is not enough to

boost productivity. The availability of nurses in Angola compares favorably with Sub-Saharan countries. In 2003, the MOH began refresher training of government and UNITA nurses. It has also begun upgrading 1,200 health promoters from UNITA and the government, out of a total of 6,000.

In 2005, the MOH placed five new medical doctors in each province. In some provinces, it also appointed economists to support the management of hospitals.

During the last five years, the Human Resources Department developed a strategic plan with help from WHO and Sweden. Its objective is to improve the human resources planning and management capacity of the health sector at the central and provincial levels.

A recent EU consultancy evaluated the 1997-2007 Human Resources Development Plan of the MOH. The objective was to describe the achievements and constraints and help prepare the next steps for the new Human Resources Development Plan. The final report was not yet ready in May 2006, but its conclusions should be reviewed by the Bank when available. The EU is currently supporting a special program for human resources strengthening in the Lusophone countries.

The uneven distribution of health professionals is a major problem. The MOH is trying to solve it by providing significant salary incentives to encourage health professionals to work in difficult areas. In the provinces classified as the most difficult to live (Kuando-Kubango for example), health professionals receive an incentive of 2-3 times their basic salary. The MOH is coordinating its actions with provincial governments so that they prepare themselves to absorb newly-formed and relocated personnel.

Recruitment is done through advertising of positions nationwide. The Human Resources Department is decentralizing recruitment of nurses and other personnel to the provinces. Health sector human resources are monitored using the National Human Resources Integrated Management System, under the responsibility of the Ministry of Public Administration.

The Human Resources Department's priority is to convert the existing promoters, heath practitioners, and auxiliary nurses into basic nurses. To that effect, it wants to increase its capacity to provide continuous education courses to all categories and specialties of health professionals. It intends to link the training of staff to progress in their professional career. However, the MOH does not have enough qualified trainers, either for the continuous education process or for the basic nurse training schools and technical-professional health schools (ETPS). Also, the MOH does not have sufficient funds to meet this objective, although some of the EMRP funds can be used for training.

The MOH also has difficulties to implement the Human Resources Development Plan in the area of health services planning and management. With the support of the Italian Cooperation, the MOH has started a pilot experiment in Lubango province, where it is

developing a training course on health facility management, and a supervision manual to assure the quality of training.

In the long term, the MOH plans to develop specializations in hospital management, human resources management, and to complete the revision of the curriculum for the training of nurse midwifes. Nursing specialties will reach only mid-level nursing. The ultimate objective of the MOH is to have each of the health posts staffed with a trained mid-level nurse.

In the case of the Armed Forces, there seems to be no shortage of nurses or medical doctors. Over the last 10 years, the Armed Forces Directorate of Health Services has been developing a solid cadre of highly qualified medical specialists.

Health Professionals Training. Doctors are trained at University Agostinho Neto's School of Medicine through a 6-year course. The school, opened in 1972, has a good reputation. It has been producing doctors regularly at the pace of 60 new doctors a year (fewer during some years). The school is functioning in a modern building constructed with funds from the EU and Spain.

The Dean considers that the medical school can produce a maximum of 70-80 new graduates per year. This is because Americo Boavida, the university hospital, can receive. 120-150 new students every year at the pre-clinical stage, and is currently close to that amount. It also takes into consideration a high student attrition rate. Post-graduate studies (for example for specializing MDs) are also provided by the school, with graduation policies defined by the MOH and the Armed Forces.

It is difficult for the Medical School to retain its professors. The main reason is the lack of incentives, including salaries, post graduation opportunities, and career progression and the lack of working conditions especially in the clinical area. A revision of the Medical School curricula is being done with the support of WHO and the World Federation of Medical Schools.

There is a need for more than one medical school in Angola. As the government uses a theoretical target of one medical school per 2 million inhabitants, this means that about 3-4 more schools would be required. In practice there will be fewer schools because there is not a critical mass of experienced teachers available (unless the government decides to import doctors). At least one more school is necessary because Angola will soon start an epidemiological transition from infectious to chronic diseases and the country will need more specialized physicians. The Agostinho Neto School of Medicine is prepared to support the Ministry of Education to open new medical schools in the southern provinces. There is a lag of four years between the decision to create a course and its actual inauguration.

The Armed Forces are creating their own school of medicine in partnership with the Faculty of Medical Sciences of the Lisbon New University, and within the framework of the newly created Military Academy. In principle the school will serve the needs of the military, but it does not exclude the possibility to enroll civilian students later on.

Other health professionals are trained mainly through a network of basic nurse schools (ETS Escolas Tecnicas de Saúde), located in the provinces. These schools support the continuous education program, the upgrading of health promoters and practitioners, and the training of new basic nurses. The five ETPS provide nurse specialization training and train mid-level professionals.

Annex 1 presents the medical courses that exist in the provinces, including the courses given by the basic-level nursing schools and the ETPS. In some provinces there are still some IMS – Instituto Medio de Saúde (old name referring to the mid-level health training schools), but they will be closed in the next two years. Only the ETPS will be authorized to train mid-level health professionals including nurses, laboratory technicians and other specialties. On an interim basis some of the ETS may provide specialized training – such as for laboratory technicians, but this is being reviewed by the MOH.

The Instituto Superior de Enfermagem - ISE (Nursing College) provides a higher level of nurse training. The ISE depends from Agostinho Neto University and started its activities about two years ago. It provides a 4-year training course for general nurses. In the next five years, two new ISE are programmed to open in Lubango and Huambo.

To improve the quality of training and build capacity in the ETPS system, the MOH has developed partnerships with health teaching institutions overseas. The EZTPS in Luanda has an agreement to train teachers in the Lisbon College of Health Technologies, with the support of the Portuguese Institute for Aid to Development. The European Union is funding physiotherapy and orthopedics training for nurses based on the experience of Dom Bosco University in El Salvador.

The Role of the Private Sector in Human Resources Training. The last five years have seen the opening of some new private schools for training of health professionals. In Luanda the two most important are the ISPRA that trains para-medical staff, such as laboratory technicians and nurses, and the Piaget Institute School of Medical Sciences that will graduate its first 10 doctors this year. Both institutions are using the Military Hospital for their practical training. It is not clear who is responsible for the quality control of these courses.

Churches are among the private not-for-profit institutions that have traditionally provided training for health staff, particularly nurses. This activity was mainly done through Christian churches in Huambo, Bié, Malange, and Catholic churches in Cunene, among others. Some of the church training schools were very small and trained very few nurses per year, but the quality of the training was well recognized. This has continued after independence, although some of them closed because of the security situation during the civil war and because some of the church hospitals were nationalized. During the second half of the eighties, there was a movement to integrate these training schools into the MOH training scheme and their training and diplomas formally recognized by the health system.

Drugs and Logistics. At the end of the 1990s, the MOH began to use an adaptation of bidding documents from the Bank and other international organizations to launch tenders for essential drugs kits. There are evaluation committees, but it is not clear whether they use standard rules and evaluation criteria. Their recommendations are sent to the Minister or Vice Ministers for ratification. Payments are made through the Department of Planning and the General Secretariat of Health, i.e. the Minister. Often direct contracting is made for emergency acquisitions.

National hospitals and Provincial Health Directorates have the right to do their own procurement. They do not systematically use standard documents and procedures. In principle the process should be supervised by the Inspection Department of the MOH. Frequently equipment and drugs are acquired by direct negotiations and sole source. At the present time, the risk of corruption is high.

Until recently, the government owned a central purchasing company called Angomedica, in charge of importing and warehousing of drugs and equipment. It also manufactured some essential drugs such as aspirin, cough syrups, and antibiotics, which it sold to health facilities and provinces. This parastatal was poorly managed and had difficulty to collect money from its creditors, i.e. the MOH and provinces. It was dismantled and its assets sold, except for warehouses that are still used by the MOH.

Drugs and equipments acquired by the MOHE are stocked in three warehouses located in the provinces of Luanda, Benguela and Namibe, which serve as distribution points for the northern, central and southern provinces. The warehouses need repairs and their staff needs basic training on stock management. From the warehouses, drugs are sent by truck to provincial hospitals and local warehouses. From there, drugs are sent to municipalities. Leakages of drugs are common during transportation, but there is no data on their extent.

There are prospects for improvement of procurement of drugs and equipment. First, the MOH has indicated its will to improve the system. Second, the basic rules and procedures exist. Third, the Bank through the EMRP, as well as other partners such as the Global Fund and the EU are providing technical assistance to improve forecasting of needs and tendering procedures. Through PASS, the EU is helping the MOH create instruments and standardized procedures for the import of drugs and equipment, and establish the base for a National Pharmaceutical Policy. The Global Fund is supporting the contracting of a private agent to help the MOH purchase, distribute, and monitor the large amounts of drugs needed for the control of malaria, TB and HIV/AIDS. There is room for significant gains in terms of achieving more competitive prices and reduction of wastage.

Conclusions and Recommendations

Conclusions. WHO describes four basic functions that are influential to attain the desirable goals in improving the population's health: financing, service provision, resource generation, and stewardship.

Health system financing is the process by which revenues are collected, accumulated, and allocated to specific health actions. The process includes revenue collection, fund pooling, and purchasing.

Service provision includes the way inputs are combined to permit the delivery of a series of interventions or health actions. These comprise personal health services in the areas of prevention, diagnostic/therapeutics, rehabilitation—and non-personal services including health information, education and communication, legislation, and the provision of basic hygiene and sanitation facilities.

Resource generation is critical to allow the health system to perform to its potential. Resources include those from institutions that produce inputs—human resources, physical resources such as facilities and equipment, and knowledge—to the functions of service provision and financing. Education and research centers, construction firms, and organizations producing drugs and medical equipment also fulfill these roles.

Stewardship extends beyond the conventional notion of regulation. It involves identifying strategic directions for the health system as a whole, setting, implementing and monitoring the rules of the game for the health system; assuring a level playing field among all actors in the system (particularly purchasers, providers and patients) and nurturing the communication and interaction between the different stakeholders.

The Angolan health system is not performing well in any of the functions referred above.

As regards **the health system financing function**, even if increased amounts of funds are being allocated to the sector, they often do not result in adequate production of services. Health services do not reach the poorest sections of the population, and they are not well oriented to respond to burden of disease priorities.

Given the country's huge economic potential, it is expected that in the future Angola will be able to respond to the financing needs of the health system without external support. But at the present time, due to the enormous task of rebuilding the country after more then 20 years of war and social disintegration, there is a need for international financing in specific areas of the system.

Because of its strategic importance, Angola should be able to mobilize international funds relatively easily, including funds for the health sector. Support from international agencies will depend on the political will and commitment of the government and the existence of clear policies and implementation practices towards poverty reduction. The decentralization process must be closely supervised and the capacity of the structures to

be decentralized – hospitals, provinces, and municipalities – need to be strengthened early in the process.

The service provision function suffered deeply from the prolonged war and the irregular arrival of inputs and resources. It was also affected by erratic strategies and poor implementation of health policies and programs, especially during the 1990s.

Even if the MOH's stated objective is to develop primary health care (such as immunization and maternal health services) that provide preventive services to the population, the reality is that a significant part of the resources -- financial, human and infrastructure -- is dedicated to tertiary hospital care. This misallocation has to be reversed if the government wants to meet its objective of "improving access to primary health care with emphasis in mother and child care"[3], as stated in various government documents,

The health sector also needs to improve the efficiency of the network of health facilities at the municipal level, as well as productivity of provincial and national hospitals.

Another area to improve is disease control where the MOH should start taking steps to diminish the number of vertical programs and integrate those programs into broader strategies such as the reduction of maternal mortality.

During the last 7-8 years, **the resource generation function** has made significant improvements, especially in the areas of human resources development that has received attention from the MOH and the Ministry of Public Administration. Nevertheless the MOH needs to review its human resources policy in line with the new reality of peace. The MOH needs to place more health professionals in the municipalities and improve the quality of services.

The roles of the University and the Medical School need to be reviewed. The Medical School needs to increase its capacity or the sector will face a shortage of doctors as the health facilities being reconstructed come on line. The imbalance in the distribution of health staff needs to be addressed using innovative incentives that will encourage professionals to work in the provinces.

The procurement of drugs and medical equipment as well as the overall logistical system need to be improved. For the government to acquire this kind of expertise, one option is to contract a firm specialized in logistics that would train logistic specialists for the health sector.

Finally **the stewardship function** has been negatively affected by the war and by years of lack of political commitment to the health sector. The existence of a unity government entails significant political compromises in the sector. Different political views in the same ministry currently contribute to inconsistencies in setting the rules of the game, enforcing the regulations, and monitoring service delivery. The stewardship function

[3] Programa Geral do Governo 2005-2006 – Governo de Unidade e Reconciliação NAcional

needs to be reinforced because it is the one providing the guidance and governing principles that constitute the framework for all other functions to operate.

Recommended Next Steps. As in other post-conflict countries, Angola's health sector is undergoing rapid and dramatic changes. The next elections will bring a new government and eventually more clarity in terms of leadership, coordination and stability, thus creating a new environment for the development of the health sector.

There are a number of partners currently supporting projects in the health sector, but some of the major financiers like the EC will be soon completing their projects (the PASS will be closing in 2 years). The task of reconstruction is huge and there will be a need for further international assistance to the sector. Given the size of the country and the extent of the problems, most donors can only provide support to some provinces or to some functions of the MOH.

The World Bank has a role to play in this process. Its knowledge and authority are well recognized by the MOH who would like additional Bank support besides HAMSET and the health component of the EMRP. HAMSET, after some initial difficulties before effectiveness, seems to be performing well and soon project implementation and disbursements will pick up pace, opening the opportunity for a new project.

A new Bank operation could help the health system carry out decentralized interventions to control poverty-related diseases. During various interviews, there was strong consensus that the following areas would warrant Bank support: (i) strengthening the service provision function, especially in the provinces and selected municipalities; (ii) improving the resource generation function, especially in the human resources development area; and (iii) reinforcing the stewardship function, principally the finalization of regulations linked to existing laws, the dissemination of norms, and the supervision of services in the provinces and municipalities.

Based on the conclusions of the recent "Nineteenth Consultative Council of the MOH" and on recommendations of different studies of the Angolan health sector, the following framework could be used to develop appropriate sector support.

- Need for clarity and better definition of health sector objectives
- Need to develop and strengthen the health system management and health information system.
- Improve resource allocation process.
- Improve skills for procurement, warehousing and distribution of drugs and equipment.
- Support the Human Resources Development Plan including: (i) costing of human resources requirements and training; (ii) prioritization of training of multi-skilled health workers; (iii) in-service training at all levels in specific areas; (iv) improvement of the working conditions and provision of incentives; (v) revision of curricula for nurses; and (vi) support to post–graduate studies for mid-level staff as well as for doctors.

- Improvement of health system network focusing on primary health care, and mother and child survival, through the strengthening of community and outreach interventions.
- Strengthening of health promotion through community health workers (health promoters, traditional birth attendants, and traditional healers in health interventions).

Under this framework, the following studies would improve sector analysis and provided added knowledge for sector support:
:

1. *Human resources training and incentives*. The study would: (i) analyze the gaps in training that the new curricula are not covering; and (ii) propose an incentive policy to improve morale and productivity of health staff and encourage them to work in the provinces and municipalities.

2. *Review of health information system*: The study would provide alternatives to strengthen the Health Management Information System (HMIS); (ii) recommend how to implement the HMIS in a decentralized manner; (iii) define how the various sub-systems would be integrated; and (iv) recommend how to properly use data for decision-making at the various levels.

3. *Studies on Health Economics.* The studies would: help the MOH better define base costs for budgeting, including the costs of health services on average and in different regions of the country; and (ii) provide evidence-based criteria for the decentralization of hospital services.

These studies would take about 3-4 months to be completed. They would cost an estimated US$100,000 (assuming a team of 2 specialists for 3 months and each specialist costing about US$15,000 a month).

Taking into consideration sector constraints, and choosing interventions that would have an impact in the short to medium term, support to the government could be provided by donors in at least two areas:

(i) <u>Strengthening of human resources capacity management and service provision</u>.

This activity would help the Human Resources Department of the MOH, construct/rehabilitate two new ETPS and equip the existing ETPS with laboratories. The scope of activities would be adjusted in function of the amount of rehabilitation supported by China. The construction of the ETPS would follow the model of the Lubango ETPS (financed by the Bank through the first Health Project).

In addition to infrastructure, support would be provided to curricula revision, improvement in the quality of training and post-graduate training of doctors,

development of a sound policy for community-based workers, and training of health promoters.

Furthermore, capacity building would be provided to help improve health planning and management by the provincial teams and for the development of the HMIS (including equipment of materials and training of personnel).

(ii) A second alternative for support could be the improvement of health service delivery in selected provinces (to be defined; one alternative is to continue to support the EMRP provinces – Moxico, Malanje, Bié and Kwanza Norte)

This support would help strengthen primary health care and develop community-based interventions associated to a strategy of mobile teams. Technical assistance would be provided in the areas of human resources development, including support to the ETPS and ETS in these provinces. It would help train teachers and improve teaching conditions. It would also help the MOH improve the HMIS and the logistical system in these provinces.

BIBLIOGRAPHY

Programa Geral do Governo 2005-2006 (General Government Program) – Luanda 2005 – Ministério do Plano – Governo de Unidade e Reconstrução Nacional

Proposta de Orçamento de 2006 para o Ministério da Saúde- GEPE- Ministério da Saúde 2005 (documento interno)

Conclusões e recomendações do 19 Conselho Consultivo do Ministério da Saúde de Angola (Draft to be approved) – Novembro 2005

Strategic Plan for the accelerate reduction of Maternal and Child Mortality in Angola 2004-2008; Luanda 2004; Ministerio da Saúde de Angola – DNSP; UNICEF, UNFPA, WHO

Lluis Viñals, Estudo da Comparticipação dos Utentes nos custos da Saúde nas Unidades Sanitárias do Serviço Nacional de Saúde de Angola - Dezembro de 2005 – Ministério da Saúde d Angola - PASS

Lluis Viñals, Estudo de Custos das Unidades Sanitárias do Serviço Nacional de Saúde de Angola no ano de 2004 – Novembro de 2005 – Ministério da Saúde de Angola - PASS

Adérito Sanches, Rogério Pinto e Paula Figueiredo, Diagnóstico Institucional do Ministério da Saúde e Plano de Reforço da Capacidade Institucional a curto Prazo, Fundo Global – PNUD- Luanda Novembro 2005, Revisão Fev. 2006

Connor, Catherine, Yogesh Rajkotia, Ya-Shin Lin, and Paula Figueiredo. October 2005. Angola Health System Assessment; Bethesda, MD: The Partners for Health Reform plus Project, Abt Associates Inc.

Health systems performance assessment: debates, methods and empiricism - edited by Christopher J.L. Murray, David B. Evans. 2003 World Health Organization

Annex 1 – Table with the exisitng courses for Nurses and Para-Medics

Courses (Health professionals Nurses and Diagnosis/Therapeutics Technicians)		L. Norte	L. Sul	Moxico		Malange	Namibe	Huambo	Huíla	Uíge		Zaire	Bengo	Benguela		Bié		Cabinda	Kunene	K. K.	Luanda	K. Sul	K. Norte	
		ETPs	ETPs	IMS	ETPs	ETPS	ETPs	ETPS	ETPS	IMS	ETPs	ETPs	IMS	IMS	ETPs	IMS	ETPs	ETPS	ETPs	ETPs	ETPS	ETPs	IMS	ETPs
Beginning (Regular)	Auxiliary nurse																		x					
	Clinical Analysis							x	x												x			
	General Nurse								x															
	Pharmacy																				x			
	Physiotherapy																				x			
	Pathologic Anatomy																				x			
	Nutrition and Dietetics																				x			
	Cardio/ Pneumology																				x			
	Environmental Health																				x			
	Dentistry							x																
	Optician																				x			
	Radiology							x													x			
Specialties (Nursing)	Anesthesiology and Recovering							x	x												x			
	Midwifes					x		x	x												x			
	Intensive Care																				x			
	Pediatric Nurse								X															
	Surgical Instruments							x													x			
	Ophthalmology nurse																				x			
Promotion (Upgrade in career)	General Nurse			x		x		x	x	x			x	x		x		x			x		x	
	Auxiliary nurse	x	x		x		x	x	x			x	x		x		x	x	x	x		x		x
	Orthopedic Prosthetics																				x			
	Pharmacy													x				x			x			
	Radiology																	x			x			
	Medical Statistics																	x						
	Dentistry																	x			x			
	Clinical Analysis												x	x				x			x			