

Data Collection Survey on the Health System in Angola

Final Report

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This report was prepared based on the information collected in Angola and Japan from November 2020 to April 2021. The recommendations are suggested by the Survey Team and do not represent JICA's official cooperation strategy for the particular sector or country.

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Abbreviations

Acronym	English/Portuguese
ABC	Agencia Brasileira de Cooperaç�o Internacional / Brazilian International Cooperation Agency
ADECOS	Agente de Desenvolvimento Comunit�rio e Sanit�rio / Community and Health Development Agents
ADF	African Development Fund
ANC	Antenatal care
AOA	Kwanza
ARI	Acute Respiratory Infection
BMGF	Bill & Melinda Gates Foundation
CECOMA	Central Purchase of Medicines and Medical Resources of Angola / Central de Compras de Medicamentos e Meios Medicos de Angola
COVAX	COVID-19 Vaccines Global Access
CP	Counterpart
CRVS	Civil Registration and Vital Statistics
DAC	Development Assistance Committee
DNRH	Direc�o Nacional de Recursos humanos/ National Directorate of Human Resources
DHIS2	District Health Information Software
DHS	Demographic and Health Survey
DPT	Diphtheria, Tetanus, Pertussis
DTT	Diagnostic or Therapeutic Technicians
FAS	Social Support Fund/Fundo de Apoio Social
FP	Family Planning
GAVI	GAVI the Vaccine Alliance
GBD	Global Burden of Diseases
GDP	Gross Domestic Product
GEPE	Gabinete de Estudos, Planeamento e Estat�stica / Planning and Statistics Studies Cabinet
GF	Global Fund
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
IHR	International Health Regulation
IIMS	Multiple Indicator and Health Survey

INE	Instituto Nacional De Estatísticas / National Institute of Statistics
IPTp	Intermittent Preventive Treatment in Pregnancy
IPTp-SP	IPTp with Sulfadoxine-pyrimethamine
JBPP	Japan Brazil Partnership Program
MoH	Ministry of Health
NCDs	Non-Communicable Diseases
NTDs	Neglected Tropical Diseases
NHS	National Health System
OECD	Organization for Economic Co-operation and Development
PASS II	Provision of technical assistance service to support the health sector II/ Prestação de serviço de assistência técnica para apoio ao sector da saúde II
PDN	National Development Plan/Plano de Desenvolvimento Nacional
PDRH	National Plan for the Development of Human Resources for Health / Plano Nacional de Desenvolvimento dos Recursos Humanos para a Saúde
PMI	President's Malaria Initiative
PMTCT	Prevention of mother-to-child transmission
PNDS	National Health Development Plan/Plano Nacional de Desenvolvimento Sanitário
TB	Tuberculosis
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization



Map No. 3727 Rev. 4 UNITED NATIONS
August 2008

Department of Field Support
Cartographic Section

Source: United Nations HP. Available from <https://www.un.org/geospatial/content/angola> (Accessed 2020.11.25)

Summary

1. During almost 40 years of independence and civil war between 1961 and 2002, Angola's socio-economic infrastructure, such as roads, schools, and health facilities, were destroyed, and delivery of public services were hampered. Although the country's economy achieved rapid growth due to the high price of crude oil, which is abundant in the country's reserves, the revenues of the oil sector were not distributed to the general population, and when the oil price plummeted after 2014, the revenues of the Angolan government was reduced, creating a serious negative impact on the provision of government services.
2. Angola has a UHC service coverage index of 40, which is poor compared to the average for the African region and the average for lower-middle-income countries. The use of maternal and child health and infectious disease services must be expanded to promote UHC.
3. The maternal and neonatal mortality rates are comparable to the sub-Saharan African average and have been steadily decreasing between 2000 and 2015. Direct obstetric deaths such as gestational hypertension and pre- and post-partum hemorrhage account for a large proportion of maternal deaths, while pneumonia, diarrhea, and malaria account for a large proportion of child deaths. A high proportion of these deaths are due to preventable and treatable diseases.
4. In maternal and child health services, the national average of the percentage of pregnant women who received four or more antenatal care is at 61.1% (2015-2016), but there is a large difference between 73.8% in urban areas and 39.4% in rural areas.
5. Infectious diseases (HIV/AIDS, tuberculosis, malaria, etc.) are challenges due to interruptions in treatment and lack of access to curative and preventive medicines. With the technical support from USAID, the Central Purchase of Medicines and Medical Resources of Angola (CECOMA) is responsible for most of the public procurement of medicines in Angola. However, health facilities frequently run out of stock of medicines, and patients have to purchase medicines that should have been provided free of charge at their own expense in many cases.
6. The number of health care workers is 0.62 (doctors + nurses + midwives = 0.62 per 1,000 population), and there is a quantitative shortage of human resources for health. In addition, qualitative problems have arisen due to differences in educational content among training institutions and the lack of an established continuing education system.
7. Angola's health sector has a large number of development partners and aid achievement (amount) in support of health policy and administration, malaria control, infectious disease control, and basic health services. In recent years, Japan has been providing technical cooperation in developing human resources for primary health care and improving the

quality of maternal and child health services.

8. One of the challenges in the health sector is the lack of access to primary healthcare services. This is due to poor physical access, such as lack of medicines and health workers at health facilities, which results in out-of-pocket costs for users. Utilization is also hampered by the low quality of the services provided. To address these issues, there is a great need to strengthen the capacity of provincial and municipal health departments, which are responsible for recruiting and deploying health workers, managing the logistics of medicines, strengthening the capacity of training schools, and improving the quality of primary health care through in-service training of health workers.

1. Introduction

1.1. Background and Objectives of the Survey

In recent years, the African region has seen an increase in the number of non-communicable diseases in addition to infectious diseases, maternal and child health, and nutrition problems, and these health sector challenges are having a significant impact on society and the economy. To alleviate the impacts, most countries and the global community have been promoting the Universal Health Coverage (UHC), in which the goal is for “all people should have access to appropriate health promotion, prevention, treatment and functional recovery at a cost they can afford”. UHC can be realized by working on the following two points: “access to quality essential health services” and “protection from financial risk”.

To contribute to the promotion of UHC in Mozambique, Angola, and Nigeria in the African region, this study aimed to confirm the current status of health systems, cooperation needs, and trends in cooperation among development partners in these three countries, and to examine future cooperation policies. This report summarizes the results of the survey on Angola.

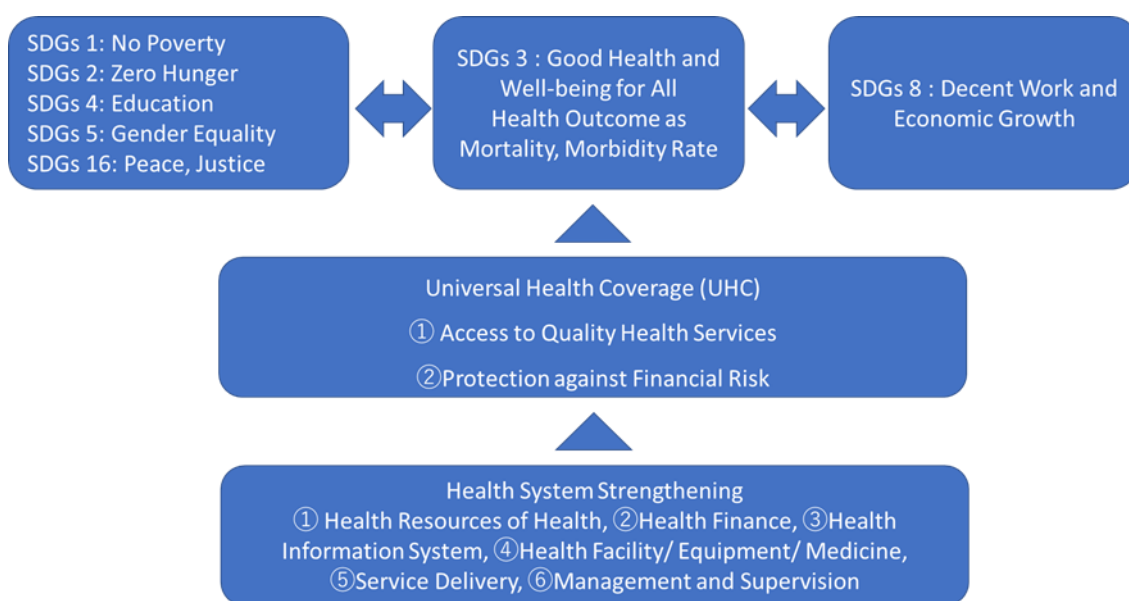


Figure 1: Health and Social Issues, UHC, and the Challenges of Health Systems Strengthening

Source: Prepared by the survey team based on UHC2030. (2017). Healthy systems for universal health coverage - a joint vision for healthy lives. Geneva: World Health Organization and the World Bank.

1.2. Survey Methodology

This study was conducted by a joint venture consisting of TA Networking Corporation and Samauma Consulting, LLC, and the study was initiated in November 2020 upon review of existing documents, as well as collection and analyzing basic information on Angola. In

December of the same year, this basic information was compiled into an interim report and discussed with JICA's Human Development Department to identify specific issues and target areas in Angola. Among specific issues in Angola, primary health care centered on maternal and child health, infectious disease control, and health human resource development were identified. From January 2021, detailed information was analyzed focusing on these specific issues through the collection of related materials by the local consultant and interviews with related organizations. Bengo Province, which is easily accessible from Luanda Province, was selected as a site for understanding the current situation in rural areas. Due to the spread of the novel coronavirus (severe acute respiratory syndrome coronavirus 2: SARS-CoV-2) infection, the number of officers of the Ministry of Health (MoH) was limited due to the recommendation of rotation work by the Angola government, and the staff of the MoH was extremely busy dealing with the COVID-19. Although it was difficult to make the appointment of the interview and obtain materials, the survey team collected the necessary information as much as possible and conducted an investigation. To identify particular needs for cooperation and to make recommendations for policies, using the collected information, a discussion with the Human Development Department of JICA was held in March 2021, after which, a final report was written as a compilation of all these findings.

2. Current Status and Issues of Health Care in Angola

2.1. National Health Status

2.1.1 Key Health Indicators

During almost 40 years of independence and civil war between 1961 and 2002, Angola's socio-economic infrastructure, such as roads, schools, and health facilities were destroyed, and the delivery of public service was hampered. However, the country's economy achieved rapid growth due to the high price of oil, which the country has abundant reserves of, and was classified as a middle-income country from 2013 to 2017. Subsequently, oil prices peaked in 2014 and plummeted, creating a serious negative impact on Angola's economy and social services, and the country was reclassified as a lower-middle-income country in July 2017. As shown in Table 1, the GNI per capita was \$3,050 in 2019. The country's weak capacity to respond to infectious diseases has resulted in a high disease burden, with the country experiencing outbreaks of yellow fever in 2016 and cholera in 2017–2018, which has caused a significant impact on the health services such as the suspension of routine health services. Table 2 and Figure 2 show the population density by province. As for population, one-third of Angola's population is concentrated in the capital province of Luanda (population density of 2,874 per km²), and more than half of the population is concentrated in the five provinces of Luanda, Huíla, Benguela, Huambo, and Cuanza Sul. The provinces of Cuando Cubango in the south and Moxico in the east have very low population densities (less than 5 per km², compared to 20 per km² for Angola as a whole).¹

Table 1: Key Social and Economic Indicators

Major social and economic indicators	Angola	Sub-Saharan Africa average	Lower-middle-income countries average	Japan
Area (1,000 km ²)	1,246.7 (2018)	NA	NA	364.6 (2018)
Total population (1 million people)	38 (2019)	NA	NA	126.2 (2019)
Gross domestic income (GNI: US Dollar 1billion)	87.2 (2019)	NA	NA	5,364 (2019)
GNI per capita (US Dollar)	3,050 (2019)	1,550 (2019)	2,189 (2019)	41,690 (2019)
Poverty headcount ratio (% of population under 1.90\$/day: %)	47.6 (2018)	42.3 (2015)	14.2 (2015)	0.7 (2013)
Primary education completion rate (%)	46.2 (2011)	68.8 (2018)	90.8 (2018)	NA
Life expectancy at birth (years)	60.8 (2018)	61.3 (2018)	68.4 (2018)	84.2 (2018)
UHC Service Coverage	40 (2017)	44 (2017)	55 (2017)	83 (2017)

Source: World Bank Open Data

¹ Definitive Results of the 2014 Census

Table 2: Population Density by Province
(calculated using 2020 population estimates)

Region	Province	Area (km ²)	Population ²	Population density
North	Cabinda	7,270	847,377	117
	Zaire	40,130	720,902	18
	Uige	58,698	1,761,367	30
North Central	Luanda	2,417	8,523,574	3,527
	Cuanza Norte	24,110	524,569	22
	Malanje	97,602	1,175,886	12
East	Bengo	31,371	462,598	15
	Lunda Norte	103,760	1,030,631	10
	Moxico	223,023	638,615	3
South West	Lunda Sul	77,637	649,133	8
	Cuanza Sul	55,600	2,236,581	40
	Benguela	39,826	2,611,074	66
South Central	Namibe	57,091	608,649	11
	Huambo	34,270	2,471,780	72
	Bié	70,314	1,765,495	25
South	Huíla	79,023	2,997,267	38
	Cuando Cubango	199,049	907,681	5
	Cunene	87,342	1,194,495	14

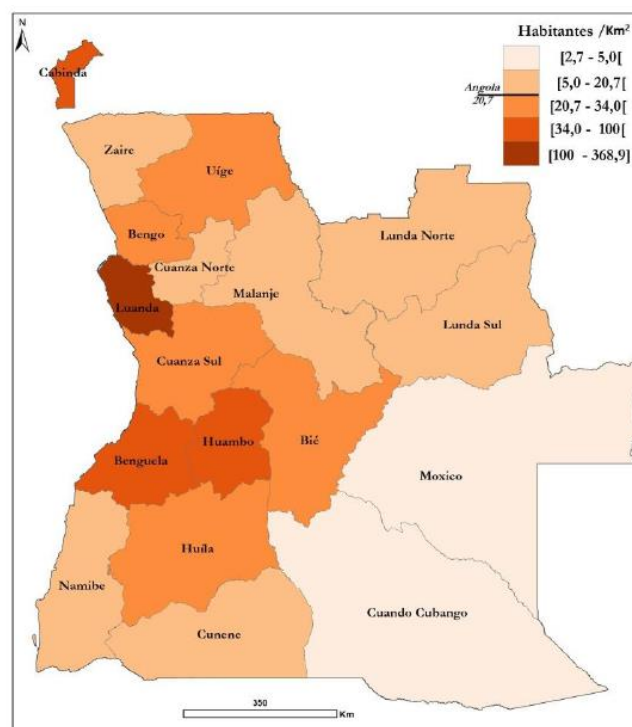


Figure 2: Population Density (2014)

Source: Resultados Definitivos do Censo 2014

² INE: PROJEÇÃO DA POPULAÇÃO 2014-2050 (November 2016)

The WHO organizes key health indicators into inputs, outputs, outcomes, and impacts levels according to a concept of “results chain”³, and Table 3 shows key health indicators for Angola, sub-Saharan Africa, and lower-middle-income countries based on this methodology. Angola’s maternal mortality rate (per 100,000 live births) and neonatal mortality rate (per 1,000 live births) are estimated to be 241 (2017) and 27.6 (2019), respectively, which is comparable the average for sub-Saharan Africa. When compared to the sub-Saharan Africa and the lower-middle-income countries average, further significant progress is needed among indicators at the outcome level such as the proportion of demand for family planning satisfied by modern methods, the proportion of births attended by skilled health staff, and the coverage of DPT immunization (% of children ages 12–23 months vaccinated) in Angola.

The output and input level indicators are directly related to the initial steps towards improving the quality of health services. In Angola, the number of doctors (per 1,000 population) and the total number of hospital beds (per 1,000 population) are at the same level with countries that are in the same region and/or with the countries that have a similar level of income, however, the number of nurses and midwives (per 1,000 population) is lower. The number of health professionals required to achieve UHC is estimated to 4.45 (doctors + nurses + midwives = 4.45 per 1,000 population)⁴, while in Angola it is only 0.62. At the output level, the Antiretroviral therapy coverage for HIV patients was 27.0% and tuberculosis treatment success rate was only at 25.0%, which is considerably worse than the sub-Saharan African averages (70% and 82%, respectively). Although an outdated data from 2008, it is also worth noting that among the impact level indicators, 4.5% households in Angola has had an incidence of catastrophic expenditure (which accounts for 25% of the household’s total consumption or income), which is more than twice as high as the sub-Saharan Africa average of 1.9% (2019).

³ WHO (2018) Global Reference List of 100 Core Health Indicators

⁴ WHO (2016) Health workforce requirements for Universal Health Coverage and the sustainable development goals

Table 3: Key Health Indicators

Key Health Indicators	Angola	Sub-Saharan Africa average	Lower-middle-income countries average
Impact			
Maternal mortality rate (per 100,000 live births)	241 (2017)	534 (2017)	265 (2017)
Neonatal mortality rate (per 1,000 live births)	27.6 (2019)	27.5 (2019)	23.8 (2019)
Incidence of catastrophic expenditure at 25% of household total consumption or income (%)	4.5 (2008)	1.9 (2015)	3.3 (2015)
Outcome			
Demand for family planning satisfied by modern methods (% of married women with demand for family planning)	12.5 (2016)	27.1 (2017)	43.5 (2017)
Births attended by skilled health staff (%)	49.6 (2016)	59.9 (2016)	73.1 (2016)
Immunization, DPT (% of children ages 12–23 months)	57.0 (2019)	73.5 (2019)	83.9 (2019)
Prevalence of stunting, height for age (% of children under 5)	37.6 (2015)	33.0 (2019)	30.1 (2019)
Output			
Antiretroviral therapy coverage (% of people living with HIV)	27.0 (2019)	69.7 (2019)	–
Tuberculosis treatment success rate (% of new cases)	25.0 (2017)	82.0 (2017)	84.0 (2017)
Input			
Number of physicians (per 1,000 population)	0.21 (2017)	0.23 (2017)	0.80 (2017)
Number of nurses and midwives (per 1,000 population)	0.41 (2018)	0.99 (2018)	1.79 (2018)
Number of hospital beds (per 1,000 population)	0.8 (2005)	1.2 (1990)	1.0 (2011)

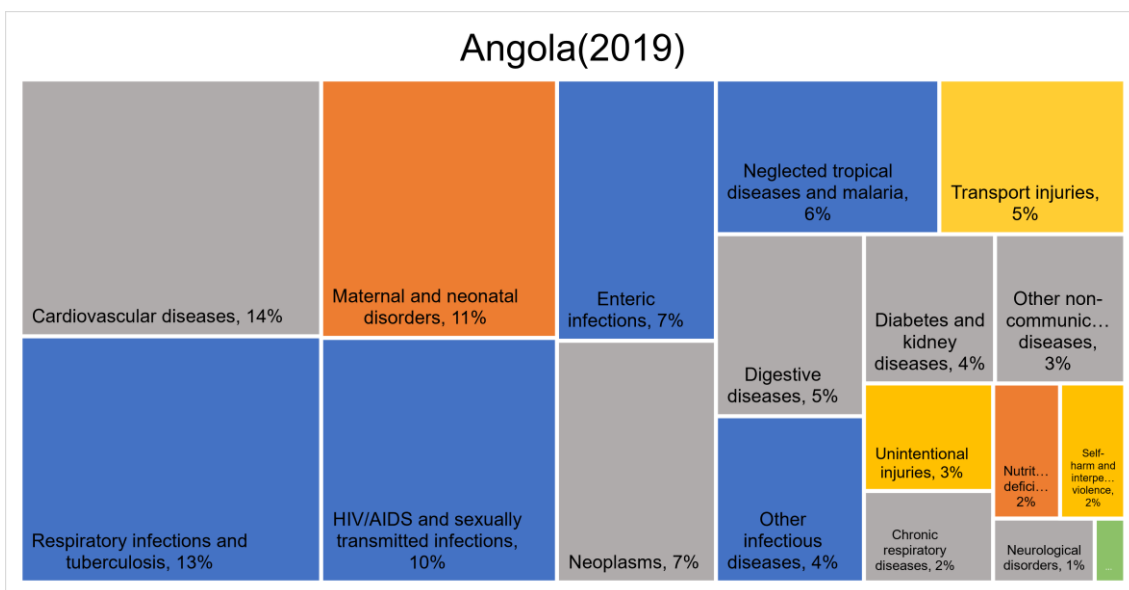
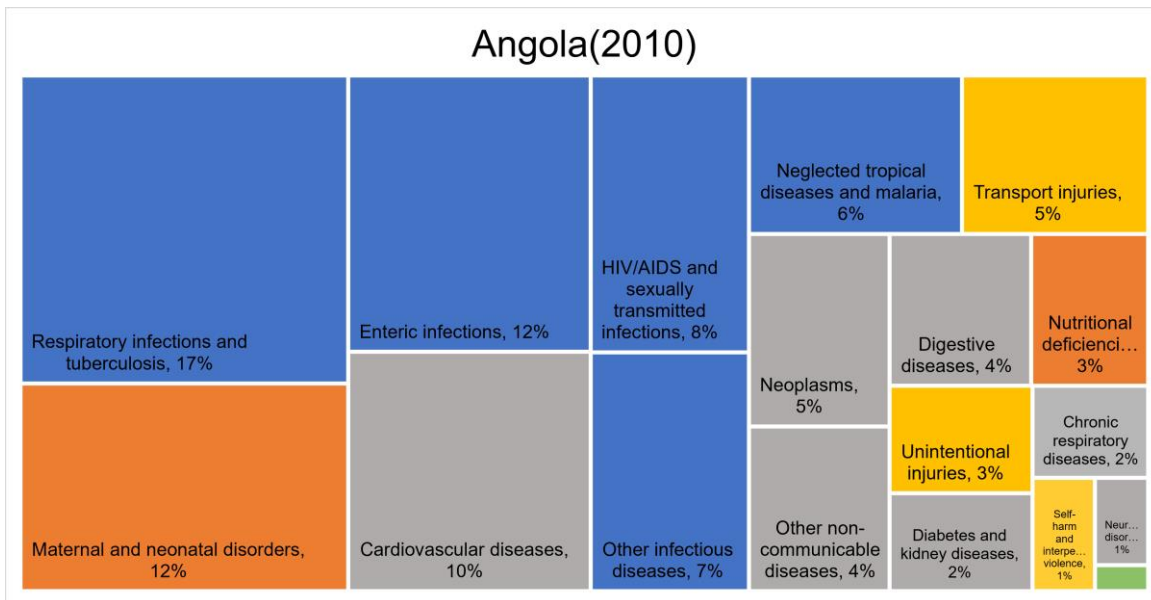
Source: World Bank Open Data and WHO Global Health Observatory Data

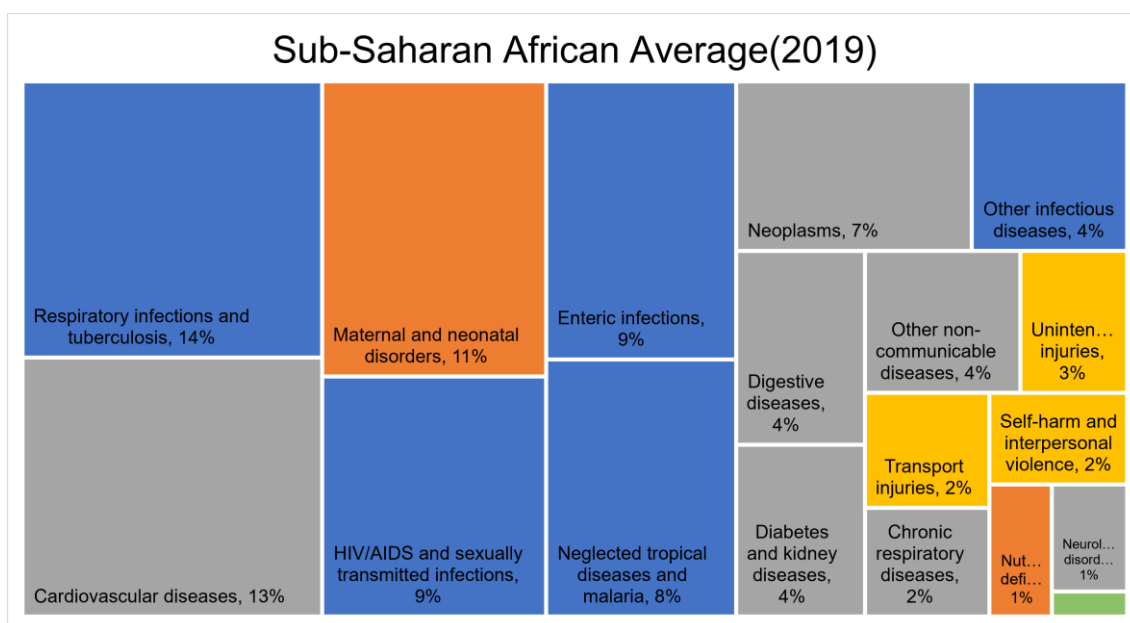
2.1.2 Disease Structure

The Global Burden of Diseases (GBD) survey was used to examine the transition of the burden of disease in Angola.⁵ With the sustained development of the African region, the disease structure has gradually shifted from being dominated by infectious diseases to a larger share of non-communicable diseases. In Angola, a comparison of the causes of death between 2010 and 2019 shows that the proportion of deaths due to infectious diseases decreased from 49% to 42%, while the proportion of deaths due to non-communicable diseases increased from 27% to 36%. A comparison of the number of deaths per 100,000 people between 2010 and 2019 shows that deaths due to infectious diseases decreased from 433.0 in 2010 to 256.6 in 2019. On the other hand, deaths due to non-communicable diseases also decreased from 245.1 in 2010 to 223.0 in 2019, but the reduction is smaller, and non-communicable diseases are increasing as a percentage of all causes of death. Among non-communicable diseases, the share of death due to cardiovascular

⁵ In terms of causes of death in GBD, the major categories are (1) infectious diseases, maternal and child, and nutrition-related diseases, (2) non-infectious diseases, and (3) injuries. In this report, we analyzed “(1) infectious diseases, maternal, child, and nutrition-related diseases” by dividing it into two categories: “infectious diseases” and “maternal, child, and nutrition-related diseases”

diseases in all deaths rose from 10% (4th largest proportion) in 2010 and 14% (1st) in 2019 and the share of death due to neoplasms rose from 5% (9th) and 7% (6th).





Note: Infectious diseases are shown in blue, maternal and nutrition-related diseases in orange, non-infectious diseases in gray, and injuries in yellow.

Figure 3: Major Causes of Death for all Ages in Angola and Sub-Saharan African Average (% of all deaths)

Source: Prepared by the survey team based on Institute for Health Metrics and Evaluation (IHME). GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington. Available from <http://vizhub.healthdata.org/gbd-compare>. (Accessed 2020.11.20)

2.1.3 Progress of UHC

To monitor the progress in achieving UHC, the UHC Monitoring Indicators have been developed. The UHC monitoring indicators consist of two major items: 1) Essential Health Service Coverage Index, and 2) Incidence of Catastrophic Health Expenditure. The UHC Service Coverage Index consists of 14 sub-indicators in four areas: (1) Reproductive, maternal, newborn, and child health (hereafter referred to as “maternal and child health”), (2) Communicable diseases, (3) Non-communicable diseases, and (4) Service capacity and access. In Angola, the UHC service coverage index was worse than the average for the region and the countries with the same level of income. As the utilization of maternal and child health and infectious diseases services were found to be low, promotion of the use of services in these areas is important for the achievement of UHC. “Service capacity and access” consists of access to hospitals (number of beds per population), human resources for health (number of health professionals per population), and health crisis response (core capacity index based on the International Health Regulations). The score in Angola was 35, higher than the sub-Saharan average of 27. Angola’s overall “service capacity and access” points are higher than the regional average but the two subcategories of number of hospital beds and number of human resources for health are lower than the regional average, whereas the subcategory of health crisis response is better than the regional average.

Regarding Angola’s indicator for the percentage of households with incidence of catastrophic expenditure at 25% of household total consumption or income is 4.5%, more than twice as high as the sub-Saharan Africa average of 1.9% (2019).

Table 4: UHC Monitoring Indicators (2015)

	Angola	Sub-Saharan Africa average	Lower-middle-income countries
UHC Service Coverage Index	40	42	57
Maternal and child health ¹	45	51	69
Infectious disease	23	37	51
Non-communicable diseases	68	69	62
Service capacity and access	35	27	54
Percentage of population with high health-related expenditure as a percentage household total consumption or income			
Incidence of catastrophic expenditure at 10% of household total consumption or income (%)	12.4 (2008)	10.3 (2010)	14.2 (2015)
Incidence of catastrophic expenditure at 25% of household total consumption or income (%)	4.5 (2008)	2.5 (2010)	3.3 (2015)

*1: “Reproductive, maternal, newborn and child health” to be precise.

Source: Tracking Universal Health Coverage: 2019 Global Monitoring report, WHO, The World Bank

2.1.4 Maternal and Child Health

(1) Changes in Maternal Mortality Over Time

The change in the maternal mortality ratio in Angola over time is shown in Figure 4. In 2000, the maternal mortality ratio was 827 (per 100,000 live births), which was very high, but in 2017 it was 241, which is a significant decrease. The country has also set a target in the National Development Plan (PDN) 2018–2022 to reach 199 by 2022.

According to the results of interviews with MoH officials, the factors behind the decline in the maternal mortality ratio were cited as follows: “The spread of cell phones, television, and radio has increased the public’s access to information”, “The number of pregnant women who understand the importance of antenatal care and visit health facilities has increased due to the improved education level of mothers”, and “The maternal mortality review committee conducts thorough investigations on the causes of deaths and feeds back to the field”.

According to the interview with the officer of the MoH, since 2012, training on maternal deaths investigation has been conducted for provincial and municipal health departments in the whole country, and it was recommended to organize the maternal mortality review committee at the provincial, municipal, and health facility levels. However, the status of their activities varies depending on the lack of budget and other factors. In the capital province of Luanda, maternal mortality review committees are not established at the provincial, municipal, or health facility

levels, but are at the central level (National Public Health Department). When a maternal death occurs, the health care providers at the health facility hold a case review meeting, and the maternal mortality review committee conducts supervision at the health facility and prepares a report based on this supervision. Maternal deaths at the community level due to home deliveries, etc. are often not reported, and actual events occurring in some cases are difficult to ascertain. If a case is reported to the municipal health department and a budget for transportation and other expenses can be secured, a community survey will be conducted.

In addition, as shown in Figure 5, the more widespread use of various health services, such as births attended by skilled health staff and pregnant women receiving antenatal care, are also thought to be related to the decline in the maternal mortality ratio.

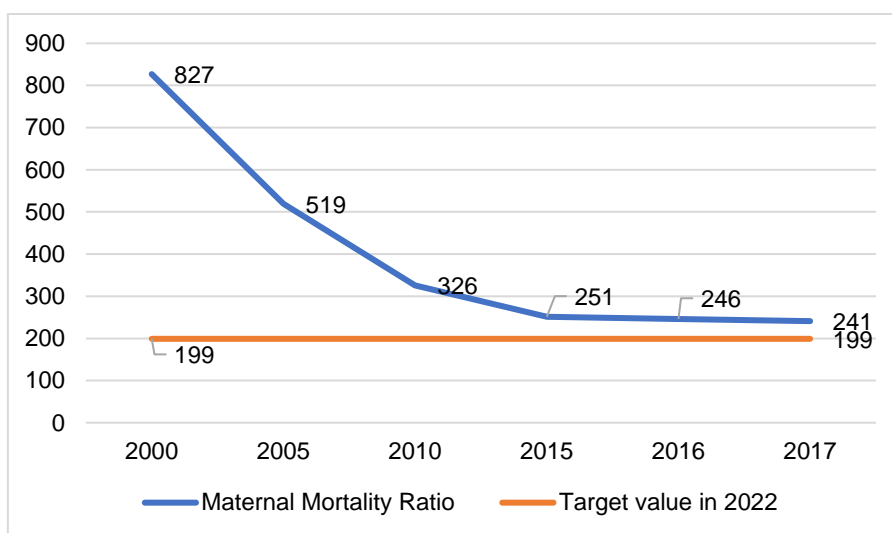


Figure 4: Trends in Maternal Mortality Ratio (per 100,000 live births) and the Target in 2022

Source: World Bank Open Data, target value in 2022 is from the National Health Plan (2012–2025).

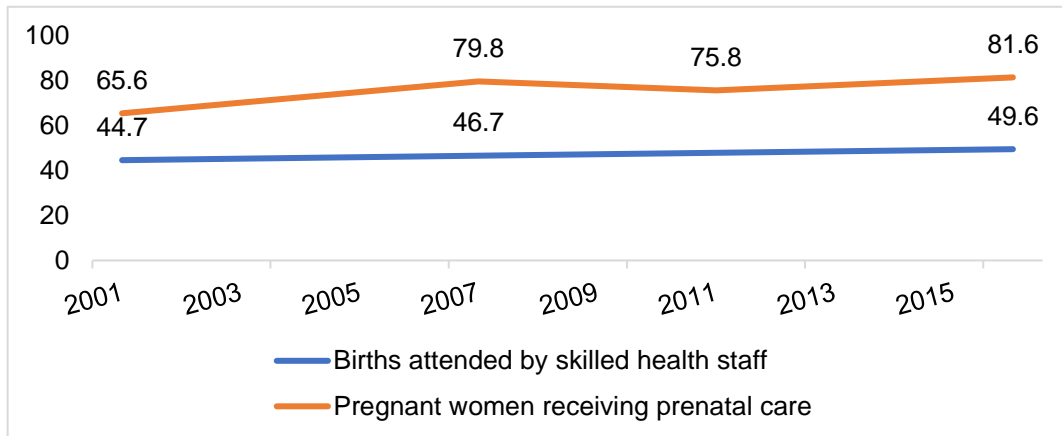


Figure 5: Trends in Births Attended by Skilled Health Staff and Pregnant Women Receiving Antenatal care

Source: World Bank Open Data

(2) Causes of Maternal Mortality

Figure 6 shows the causes of maternal mortality. Many of the causes can be avoided by emergency obstetric care (EmOC), antenatal care, childbirth attended by skilled health staff, postnatal checkups, etc. In Angola, direct obstetric deaths, such as gestational hypertensive disorders, antepartum hemorrhage, and postpartum hemorrhage, and embolism, account for a large percentage of deaths. While indirect obstetric deaths, in which a pre-existing condition worsened after pregnancy, account for 26.3%. In many cases, these deaths can be detected and treated at an early stage by regular monitoring of pre-existing diseases and blood pressure during antenatal care, as well as during postnatal checkups. In Angola, blood tests for hemoglobin, blood glucose, etc. are required during antenatal care, but many public health facilities are experiencing equipment breakdowns, personnel shortages, and stock-outs in their laboratories, so many pregnant women are given a prescription to go to private clinics for a blood test, etc. Few pregnant women, however, cannot afford these tests in private clinics. In addition, health posts and centers, especially in the rural areas, do not have a system of blood testing, and many pregnant women have to go to distant municipal hospitals to receive tests, which is often difficult.⁶

⁶ Interviews with project staff of the Project for Improving Maternal and Child Health Services through the Maternal and Child Health Handbook

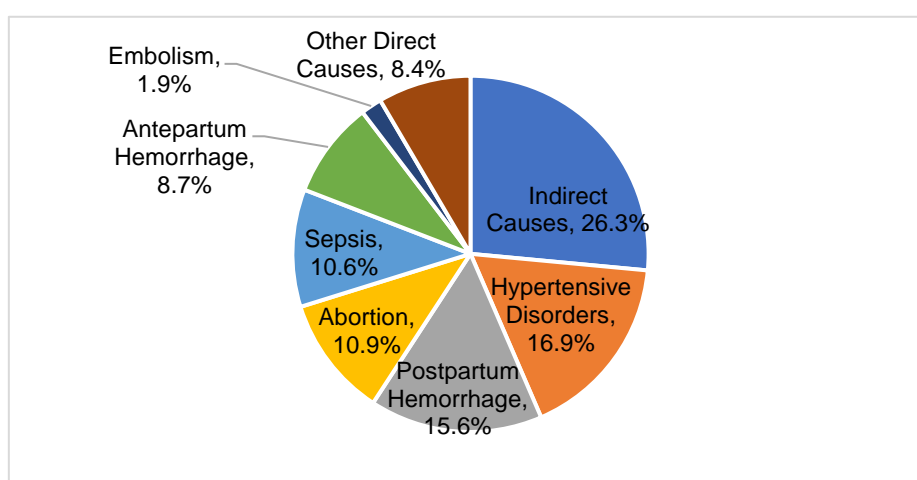


Figure 6: Major Causes of Maternal Deaths

Source: Global Causes of Maternal Death: A WHO Systematic Analysis, 2014

Table 5: Key Indicators for Maternal and Child Health (Mothers)

Region	Province	Percentage of women receiving antenatal care from a skilled provider ⁷	Percentage of women who received four or more antenatal care	Percentage of women with access to modern family planning	Percentage delivered in a health facility	Percentage delivered by skilled provider
North	Cabinda	92.6	63.8	15.6	83.2	87.9
	Zaire	97.6	79.6	8.6	85.5	87.2
	Uíge	58.7	38.1	4.3	40.2	38.6
North Central	Luanda	97.3	83.2	23.2	70.7	73.4
	Cuanza Norte	77.0	53.0	4.9	36.6	38.1
	Malanje	82.4	53.2	9.6	30.5	43.5
East	Bengo	75.4	64.8	3.5	41.1	46.4
	Lunda Norte	70.8	36.9	2.0	42.0	49.4
	Moxico	53.5	36.7	3.8	24.5	30.1
South West	Lunda Sul	89.2	60.1	4.1	44.2	50.2
	Cuanza Sul	60.0	31.5	4.6	20.2	22.9
	Benguela	78.4	58.1	11.7	47.1	50.7
South Central	Namibe	78.7	67.8	18.1	52.1	53.3
	Huambo	89.0	65.4	5.4	37.0	40.4
	Bié	73.2	49.2	2.0	17.3	20.9
South	Huíla	65.9	48.2	8.2	30.4	34.3
	Cuando Cubango	56.4	41.4	1.4	20.8	29.2
	Cunene	88.8	61.1	8.3	25.6	38.3
National Average		81.6	61.4	12.5	45.6	49.6
Rural		62.7	39.4	1.8	16.8	21.4
Urban		92.2	73.8	18.4	64.5	68.1
Wealth Quintile Lowest ⁸		55.6	34.0	1.0	12.0	17.2
Wealth Quintile Wealthiest ⁹		97.7	88.2	30.7	85.9	89.6

Source: Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016.

⁷ Professional technicians refer to physicians, nurses, and obstetric nurses.

⁸ The Wealth Quintile Lowest obtained (0–20%), as shown in the following table

⁹ The Wealth Quintile Wealthiest obtained (80–100%), as shown in the following table

Figure 7 shows the number of antenatal cares received nationwide. The national average for the percentage of pregnant women who received four or more antenatal cares is 61.1%, but there is a large difference between 73.8% in urban areas and 39.4% in rural areas. The province with the lowest rate is Cuanza Sul (31.5%), and the difference from the province with the highest rate, Luanda (83.2%), is more than 50 percentage points. This is true in rural areas, where 37.0% of pregnant women give birth without ever receiving antenatal care.

Place of delivery and the percentage of institutional deliveries by province are shown in Figure 8. Home births account for more than half (53%) of the total. The percentage of institutional deliveries is particularly low in the South and East, and home deliveries are more common. The percentage of women who gave birth at home in the presence of skilled health staff was less than 10% [1.1% doctor, 4.8% nurse, 3.2% midwife (obstetric nurse)]. Among other caregivers, 25.7% were traditional birth attendants, 47.5% were family members (and others), however, 17.5% said they had no caregivers.¹⁰ Regarding the factors for the low institutional delivery rate, interviews with MoH officers indicated that “the road conditions are poor,” “there is no money for transportation”, “the distance to the health facilities is far”, “it is difficult to travel at night,” and “some facilities are staffed only by male nurses, and pregnant women do not want to go to a facility with only male nurses”. In addition, although the Angolan government does not recommend the use of traditional birth attendants, they are recognized as an important community resource by the local population, and their trust in traditional birth attendants is particularly strong, especially in areas where access to health facilities is difficult. The National Plan for the Development of Human Resources for Health 2013–2025 (Plano Nacional de Desenvolvimento dos Recursos Humanos para a Saúde: PDRH), traditional birth attendants should be trained and integrated into the health facility team to bring pregnant women to the health facility.¹¹ According to the interviews with the MoH officers, training for traditional birth attendants has been conducted by the MoH and Ministry of Social Action, Family and Women Promotion in collaboration with UNFPA since 2012. However, the scale of the training has been reduced since 2017, and many traditional birth attendants have not received any training.

The WHO also recommends “hospitalization for at least 24 hours after delivery at a facility,” “a medical examination within 24 hours of delivery at home,” and “at least three medical examinations at 3 days, 7–14 days, and 6 weeks after delivery” because the postpartum period is a critical stage in the lives of mothers and newborns.¹² In Angola, the National Health Development Plan (PNDS) 2012–2025 also recommends postnatal checkups as “an opportunity to educate the young mother to take care of her health and her child”. However, only about a quarter (23.3%) receive a postpartum checkup within two days of delivery, and that percentage

¹⁰ Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016

¹¹ Plano Nacional de Desenvolvimento dos Recursos Humanos para a Saúde 2013–2015

¹² WHO recommendations on Postnatal care of the mother and newborn

decreases as the number of children increases. In rural areas, only 11.5% receive postpartum care. The percentage of newborn care within two days is 20.9%.

The percentage of women who are capable of use of contraception of any modern method is only 12.5%, with large regional disparities of 1.8% in rural areas and 18.4% in urban areas. The Angolan government has set a goal in its National Development Plan (PDN) 2018-2022 to have “70% of health facilities offering at least three types of modern family planning by 2022”. In Angola, contraceptive injections (Depo-Provera), oral contraceptives (pills: Microgynon, Mictolut), implants (Jadelle), and male condoms are mainly used. Many health facilities, especially in rural areas, are only able to provide Depo-Provera and the pill. In addition, the introduction of the SAYANA® PRESS contraceptive injection, which is packaged with a single dose of the drug and a syringe for easy use, has begun, and training for health care providers has been provided in some provinces.

Family planning services are free of charge but are often out of stock at health facilities, in which case they will have to purchase at private pharmacies. According to interviews with provincial health department officers, even if the provincial warehouse has stock, distribution from the provincial warehouse is often interrupted because the municipal department or health facility has not submitted monthly reports on family planning, causing stock-outs at health facilities. At a pharmacy in Bengo Province, Microgynon and Mictolut are sold at 1,200 AOA (about \$1.8, calculated at 100 AOA = \$0.1516), a pack of three male condoms costs 500 AOA (about \$0.7), and Depot Provera costs 2,500 AOA (about \$3.8).¹³ In addition, many women do not have access to family planning due to cultural factors. Some people, especially in rural areas, believe “the more children, the better,” and many women are not allowed by their husbands to use contraceptives,¹⁴ or for religious reasons as well.¹⁵

The total fertility rate in Angola is 6.2,¹⁶ with large regional disparities of 8.2 in rural areas and 5.2 in urban areas. The median interval between births is 30.8 months, with 33% having their first birth under the age of 18, and more than half (55%) having their first birth under the age of 20.

¹³ Interviews conducted in February 2021.

¹⁴ Interviews with MoH officer

¹⁵ Interviews with Bengo provincial department officer

¹⁶ Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016

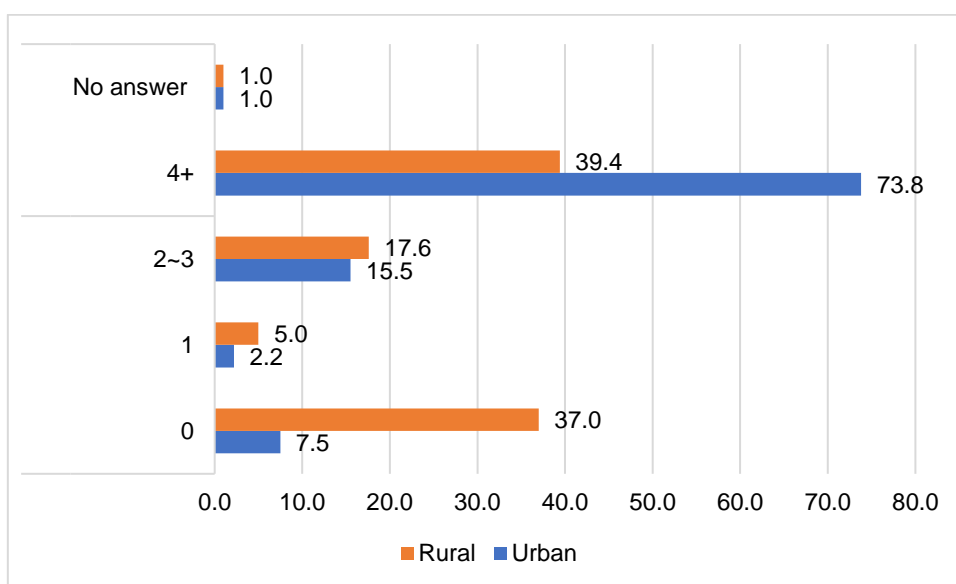


Figure 7: Number of Antenatal care Visits

Source: Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016.

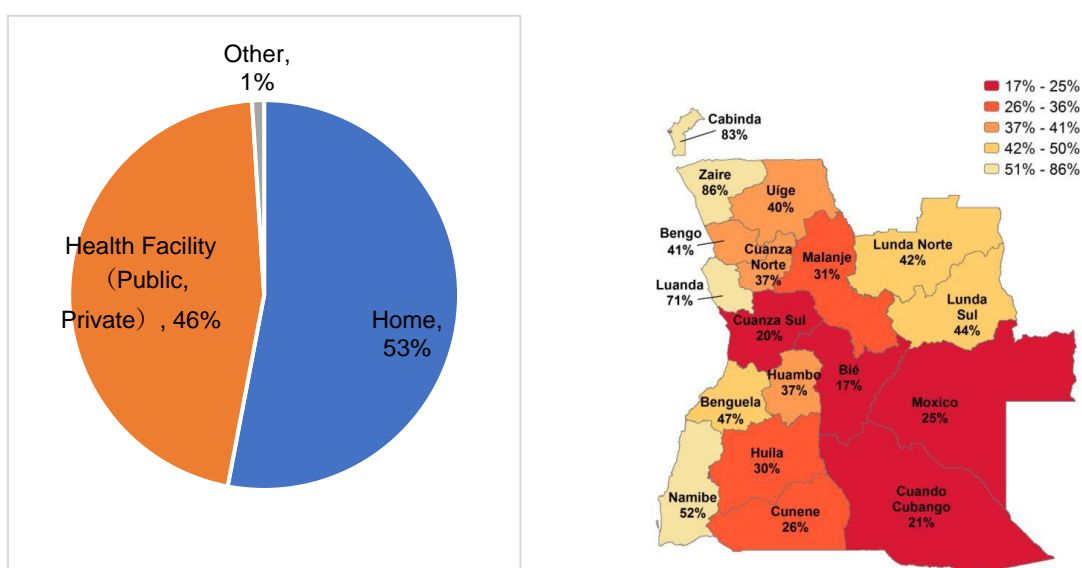


Figure 8: Place of Delivery (left) and Health Facility Births by Province (right)

(Percentage of births in health facilities in the five years prior to the survey)

Source: Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016.

(3) Access to health care

Continuum of care including antenatal care, childbirth by skilled health staff, postpartum checkups, and child checkups (vaccination) are important in maternal and child health, but the utilization of these health services is poor. The DHS investigated factors of women in accessing health care. In Angola, seven out of ten women in the country reported at least one inhibiting

factor with accessing health services when they had a health problem. Most commonly cited inhibiting factors in accessing health services include: getting money for treatment (63.0%) and distance to health facility (51.8%). Problems related to getting money for treatment are more frequent among women in rural areas (75.9%) than in urban areas (57.5%). According to interviews with the MoH officer, medical treatment is free of charge, but the problem is that patients are often required to purchase medicines at their own expense, especially in rural areas where health facilities are not fully equipped with medicines, creating a financial burden. Similarly, the problem of distance to health facilities is greater in rural areas (68.3%) than in urban areas (44.6%) (Table 6).

Table 6: Problems in Accessing Health Care (%: 2015-2016)

Inhibiting factor	National average	Urban	Rural	Wealth Quintile Wealthiest	Wealth Quintile Lowest
Getting permission to go for treatment	30.5	24.7	43.7	16.5	41.4
Getting money for treatment	63.0	57.5	75.9	47.8	79.7
Distance to health facility	51.8	44.6	68.3	37.7	70.8
Not wanting to go alone	32.0	27.1	43.2	23.6	43.8
At least one problem accessing health care	70.2	65.0	82.1	57.5	85.8

Source: Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016.

In addition, interviews with experts of “Project for Improving Maternal and Child Health Services through the implementation of the Maternal and Child Health Handbook” pointed out that the attitude and behavior of health workers discourage mothers from using health services, for example, health workers reprimand mothers who do not make childbirth at the health facility nor use child health checkups/vaccinations and have them send home. As for similar point of view, in a survey conducted in 2010 in Luanda and Uíge provinces, which asked respondents why they did not give birth at a health facility. 22.5% of respondents answered that the facility was too far away, followed by 16.3% who said they were more comfortable at home (Table 7). The same survey also asked about respondents of the quality of health services, with the total of "very low" and "low" being 33.0% on average and 49.0% in rural areas (Table 8). From the results of the Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015-2016 above, "Getting money for treatment" and "Distance to health facility" were cited as disincentives to use the service, but the results also suggest that people avoid health facilities because they are uncomfortable with the health worker’s attitude and childbirth at health facility and perceive the quality of services provided to be low.

Table 7: Reasons for Not Delivering at Health Facility (2010)

Long travel	Need to pay health workers	Not well received	More comfortable at home	Tradition	Other
22.5%	3.6%	2.5%	16.3%	12.6%	42.6%

Source: Chr. Michelsen Institute. Health services in Angola: Availability, quality and utilization. 2011

Table 8: Perceived Quality of Nearest Public Health Provider (2010)

	Very low	Low	Medium	High	Very high
Average	8.1%	24.9%	53.7%	12.3%	0.7%
Urban	5.7%	20.5%	57.9%	14.4%	1.0%
Rural	13.7%	35.3%	43.7%	7.3%	0.0%

Source: Chr. Michelsen Institute. Health services in Angola: Availability, quality and utilisation. 2011

(4) Neonatal, infant, and under-five mortality over time, regional and province comparisons

The indicator on child mortality is one of the very important indicators to measure the level of health and development status in a country and to determine the country's policies. Figure 9 shows the mortality rates of neonatal, infants, and children under five in Angola. Each of these has declined significantly, and the under-five mortality rate has declined particularly markedly. The child mortality rate has been steadily declining due to improved immunization coverage and access to other health services, as shown in Figure 10, which shows the percentage of children who have been immunized (%).

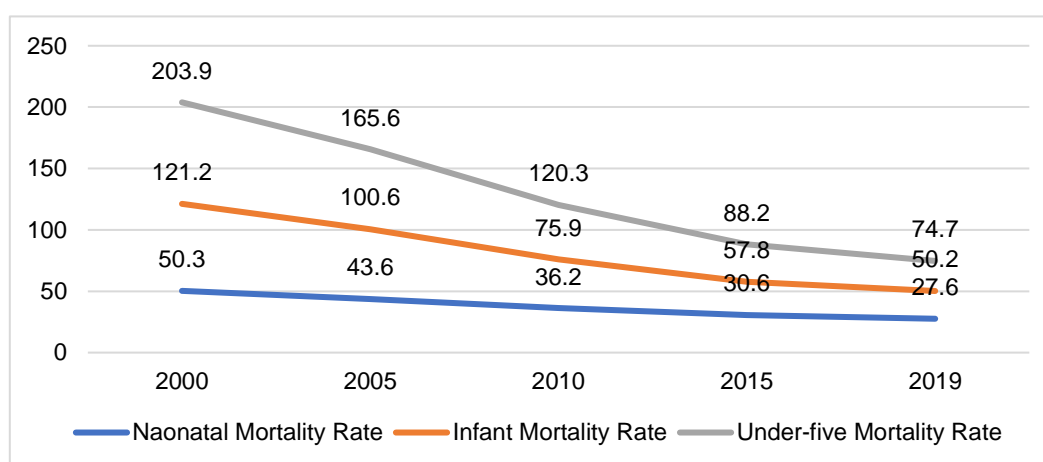


Figure 9: Neonatal, Infant, and Under-Five Mortality Rates (per 1,000 live births)

Source: World Bank Open Data

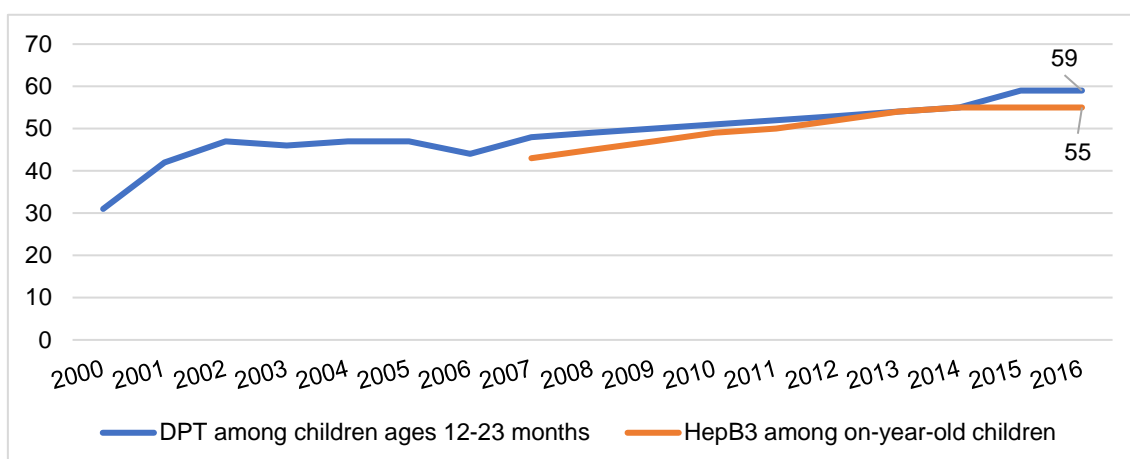


Figure 10: Percentage of Children who have been Immunized (%)

Source: World Bank Open Data

The neonatal and infant mortality rates by province are shown in Table 9, with Benguela having the highest rates, at 48 (per 1,000 live births) and 88 (per 1,000 live births), more than 10 times higher than the lowest rates in Moxico (4 and 7, respectively), indicating a large disparity among provinces.

Table 9: Neonatal and Infant Mortality Rates by Province (per 1,000 live births)

Region	Province	Neonatal mortality rate	Infant mortality rate
North	Cabinda	15	27
	Zaire	17	35
	Uige	27	41
North Central	Luanda	16	32
	Cuanza Norte	36	60
	Malanje	21	39
East	Bengo	10	23
	Lunda Norte	17	39
	Lunda Sul	9	32
South West	Moxico	4	7
	Cuanza Sul	30	79
	Benguela	48	88
South Central	Namibe	25	52
	Huambo	30	62
	Bié	16	52
South	Huíla	36	67
	Quando Cubango	24	49
	Cunene	21	42
National Average			
Rural			61
Urban			43
Wealth Quintile Lowest			62
Wealth Quintile Wealthiest			25

Source: Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016.

(5) Causes of Deaths of Children

Figure 11 shows the causes of deaths among newborns and children aged 1 month to under 5 years, with preventable and treatable diseases such as pneumonia, diarrhea, and malaria accounting for more than 50% of deaths among children aged 1 month to under 5 years. The utilization of health services for fever and diarrhea is particularly low in rural areas such as Lunda Norte and Cuanza Sul provinces, with a difference of more than 10 percentage points between urban and rural areas. The percentage of children aged 1-2 years who have received all the basic vaccinations by province is the lowest in Cuando Cubango province (8.4%), and the regional disparity is apparent in Luanda province (49.7%). One of the reasons why the vaccination rate is low in rural areas is that the vaccinations are received by the health staff at each health facility from the municipal health department and stored in the facility's refrigerator or cooler box, but the transportation costs for the health staff to receive the vaccinations are not provided. Therefore, if the distance between the municipal health department and the health facility is too far, it may be difficult for the health staff to go to pick up the vaccination, and stock-outs occur frequently. In addition, there are problems such as malfunctioning refrigerators due to power outages, lack of gas cylinders in gas-powered refrigerators, and when it is possible to inoculate multiple people from a single bottle, the vaccination process does not proceed because the bottles are not opened until multiple people have gathered (the MoH instructs that the bottles should be opened and inoculated even for a single patient, but sometimes the facilities do not open them due to limited stock).¹⁷

¹⁷ Interviews with project staff of the Project for Improving Maternal and Child Health Services through the Maternal and Child Health Handbook

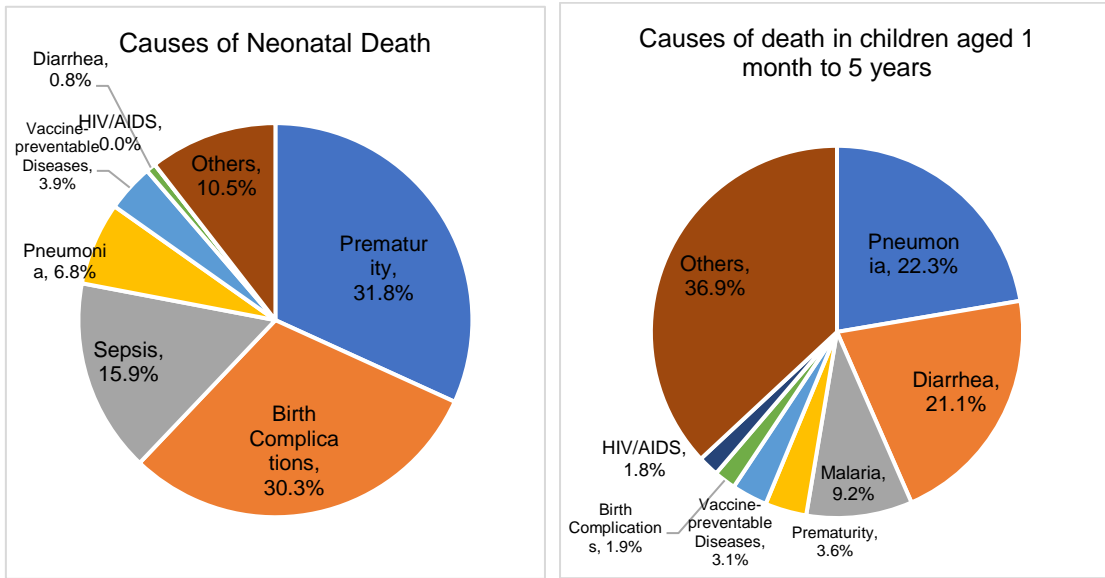


Figure 11: Causes of Death among Newborns and Children Under Five, 2015

Source: WHO-MCEE Estimates for Child Causes of Death, 2015

Table 10: Key Indicators for Maternal and Child Health (Children)

Region	Province	Percentage of children who received a checkup within 2 days of delivery	Percentage of children aged 1–2 years who have received all basic vaccinations ¹⁸	Health service utilization rates for suspected ARI ¹ among children under 5 years of age	Health service utilization rate for fever among children under 5 years	Health service utilization rate for diarrhea among children under 5 years
North	Cabinda	20.8	38.3	-	61.6	52.3
	Zaire	36.7	37.8	-	72.8	51.9
	Uige	8.6	14.8	47.2	44.1	47.6
North Central	Luanda	32.1	49.7	76.7	53.3	41.8
	Cuanza Norte	9.7	29.8	41.0	57.9	56.9
	Malanje	17.3	37.8	28.4	56.8	59.6
	Bengo	11.4	23.6	-	48.0	39.5
East	Lunda Norte	6.6	20.5	42.2	39.6	37.6
	Moxico	7.0	10.2	-	49.4	40.1
	Lunda Sul	4.7	20.9	-	46.0	48.5
South West	Cuanza Sul	10.1	18.6	-	35.8	32.5
	Benguela	21.6	26.3	-	44.1	38.6
	Namibe	30.6	30.4	-	56.9	56.8
South Central	Huambo	25.6	26.2	70.6	53.5	56.0
	Bié	8.3	10.4	-	41.5	49.8
	Huíla	19.6	23.3	29.2	60.8	49.4
South	Cuando Cubango	7.1	8.4	-	57.3	54.0
	Cunene	19.4	40.4	-	47.9	42.7
National Average		20.9	30.6	49.0	49.6	44.6
Rural		27.9	16.6	32.4	41.1	39.2
Urban		10.3	39.8	59.8	56.3	47.8
Wealth Quintile Lowest		8.5	12.5	25.2	35.5	34.7
Wealth Quintile Wealthiest		40.0	56.5	77.9	63.1	55.0

Source: Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016.

¹⁸ BCG, measles, three doses of pentavalent and polio vaccine, excluding polio at birth.

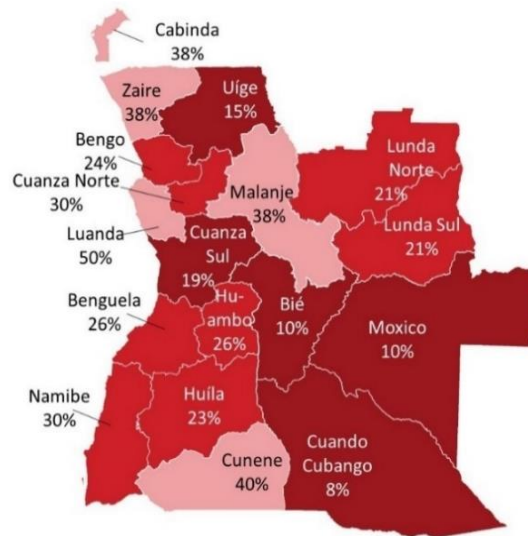


Figure 12: Percentage of Children Aged 1–2 Years who Have Received All Basic Vaccinations by Province

Source: Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016.

(6) Regional disparities in health

In Angola, there is a large regional disparity in health between urban and rural areas. Some cited reasons for this regional disparity include: “facilities are there but not functioning”, “the small number of health personnel”, and “the lack of medicines and medical equipment”.¹⁹

The reason for the “facilities are there but not functioning” is that the municipal government does not allocate budgets for the maintenance of the health facilities, and even if it does, the maintenance budget are limited and are not properly distributed to the health facilities, especially in the rural areas. As Angola is a decentralized country, the budget allocation for the health sector in the municipality is left to the municipal government. Some municipal governments receive only a limited amount of money, which leads to the problem of allocating a small percentage of the budget to the health sector, or when it is allocated, it is biased towards municipal hospitals. As a result, some of the facilities in the rural areas are aging, unmaintained, and not functioning properly. In addition, even if excellent facilities are built in rural areas, some of them are not functioning due to a lack of health personnel. For example, the Pango Aluquem municipal Hospital in Bengo Province has an operating room, but there are no doctors and it has never been used even after more than six years of construction.²⁰

The management of medicines and medical equipment is also a challenge. In February 2019, the inventory/installation status of medicines and equipment was checked at 12 facilities in

¹⁹ Interviews with MoH officer

²⁰ Interviews with Bengo Provincial officer

Balombo Municipality, 180 km east of Benguela Municipality, the provincial capital of Benguela Province, and as a result, intermittent preventive treatment in pregnancy (IPTp) with Sulfadoxine-pyrimethamine (SP) (or IPTp-SP), is lacking in 6 out of 12 facilities. In addition, most of the facilities lacked iron tablets and anthelmintics. There were shortages of medicines and equipment not only in small health posts but also in large hospitals and health centers. Even in health centers near the center of the municipality, 6 of the 9 items listed below were in short supply (Table 11). At the facilities where stock-outs occurred, health personnel filled the prescriptions, and the users took them to the nearby pharmacies to purchase them at their own expense. Although the medicines would normally be received free of charge, the patients have to pay for them themselves. In some areas, patients use the health facilities only when the medicines are delivered to them.

Table 11: Number of Facilities with Stock-Outs Medicines/Equipment in Balombo, Benguela Province

Medicines/Equipment	Number of facilities with stock-outs (Out of 12 facilities)
Adult Weight Scale	1
Child Weight Scale	0
Child Height meter	5
Sphygmomanometer	0
IPTp-SP	6
Iron	10
Anthelmintic	10
HIV Test kit	9
Malaria Rapid Diagnostic Test	0

Source: Prepared by the survey team based on Interviews with project staff of the Project for Improving Maternal and Child Health Services through the Maternal and Child Health Handbook Interview

Coupled with the lack of health service delivery system, traditional medicine is also used in Angola, especially in rural areas. The Angolan government has developed a National Policy on Traditional and Complementary Medicine in 2020, which is awaiting approval by the Parliament. The objectives of the policy are listed in Table 12.

Table 12: Objectives of the National Policy on Traditional and Complementary Medicine

- Integrate the practices of traditional and complementary medicine, scientifically evaluated, into the practice of conventional medicine, promoting research in the area for the validation of traditional knowledge in order to guarantee its effectiveness and security in the social and economic impact
- Develop a new model of health care through integrative medicine, mainly in primary health care

- Regulate the exercise of traditional and complementary medicine, as well as the production of conservation, distribution, storage, commercialization, and use of phytotherapies and other natural resources in the National Health System
- Create reference centres for Traditional and Complementary Medicine in each province
- Encourage the development of education and training programs in Traditional and Complementary Medicine for the staff of the National Health System and holders of traditional knowledge in the communities
- Promote the enhancement of knowledge of Traditional and Complementary Medicine and intellectual property rights
- Promote the qualitative and quantitative production of several species of medicinal plants and other natural resources necessary for the full development of Traditional and Complementary Medicine
- Promote the elaboration of the traditional Angolan pharmacopeia

2.1.5 Infectious Disease

(1) HIV/AIDS

The percentage with HIV (15–49 years) in Angola is lower compared to the sub-Saharan African average with the national average 2.0% (2.6% for women and 1.2% for men). By province, the positivity rate is higher in the eastern province of Moxico (4.0%), and the southern provinces of Cuando Cubango (5.5%) and Cunene (6.1%). While 82% of women and 92% of men said they had heard of AIDS, “the percentage with knowledge of HIV transmission and prevention” was 35.3% for men and 31.7% for women. The percentage of people with knowledge is higher in urban areas than in rural areas, indicating a regional disparity.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) set three 90% goals to be achieved by 2020 as a strategy to control the HIV epidemic (90–90–90).²¹ In other words, the global strategy is comprised of the following: (1) 90% of all people living with HIV will know their HIV status, (2) 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and (3) 90% of all people receiving antiretroviral therapy will have viral suppression. At health facilities, everyone can get an HIV test free of charge. HIV testing is also being promoted during antenatal care. However, in reality, HIV test kits are out of stock and consultation rooms are closed due to lack of staff.²² In Angola, the proportion of HIV patients treated with antiretrovirals is still low at 27%, it lags far behind the sub-Saharan African average of 69.6%. The lag in the control of HIV/AIDS in Angola can be attributed to the low priority given to these measures by the Angolan government and the lack of ownership, which leads to

²¹ UNAIDS. 90–90–90 - An ambitious treatment target to help end the AIDS epidemic

²² Interviews with project staff of the Project for Improving Maternal and Child Health Services through the Maternal and Child Health Handbook

poor access and availability of health services, lack of community measures, and inadequate strategy development. In addition, there are large discrepancies between aggregate data at health facilities and data sent to MoH and Provincial levels, resulting in inaccurate data.²³ In addition, since the signing of the African Union’s “Born Free to Shine Initiative” by the Angolan first lady in 2018, the Angolan government has been particularly focused on measures to prevent mother-to-child transmission.²⁴

Table 13: Key Indicators for HIV/AIDS

Region	Province	Percentage with HIV positive (15-49 years)	Percentage with comprehensive knowledge about HIV (males) ²⁵	Percentage with comprehensive knowledge about HIV (females)
North	Cabinda	0.6	88.9	63.8
	Zaire	0.5	29.8	25.4
	Uige	0.9	21.7	11.8
North Central	Luanda	1.9	47.9	54.9
	Cuanza Norte	3.0	7.0	16.8
	Malanje	2.0	37.4	18.3
	Bengo	1.9	30.0	13.8
East	Lunda Norte	3.4	17.8	23.1
	Moxico	4.0	37.6	27.9
	Lunda Sul	3.9	28.7	13.1
South West	Cuanza Sul	1.6	26.4	8.9
	Benguela	1.8	24.0	11.2
	Namibe	1.9	30.8	28.5
South Central	Huambo	1.0	12.7	8.8
	Bié	1.9	7.4	5.1
	Huíla	1.2	15.9	19.9
South	Quando Cubango	5.5	19.0	9.4
	Cunene	6.1	27.9	32.4
National Average			35.3	31.7
Rural			16.2	8.4
Urban			42.6	41.9
Wealth Quintile Lowest			11.4	7
Wealth Quintile Wealthiest			54.7	60.8

Source: Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016.

²³ Global Fund Grants in the Republic of Angola

²⁴ PEPFAR. Angola Country Operational Plan 2020. 2020

²⁵ Comprehensive knowledge means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about HIV transmission or prevention (that HIV can be transmitted by mosquito bites and by sharing food with person who has HIV).

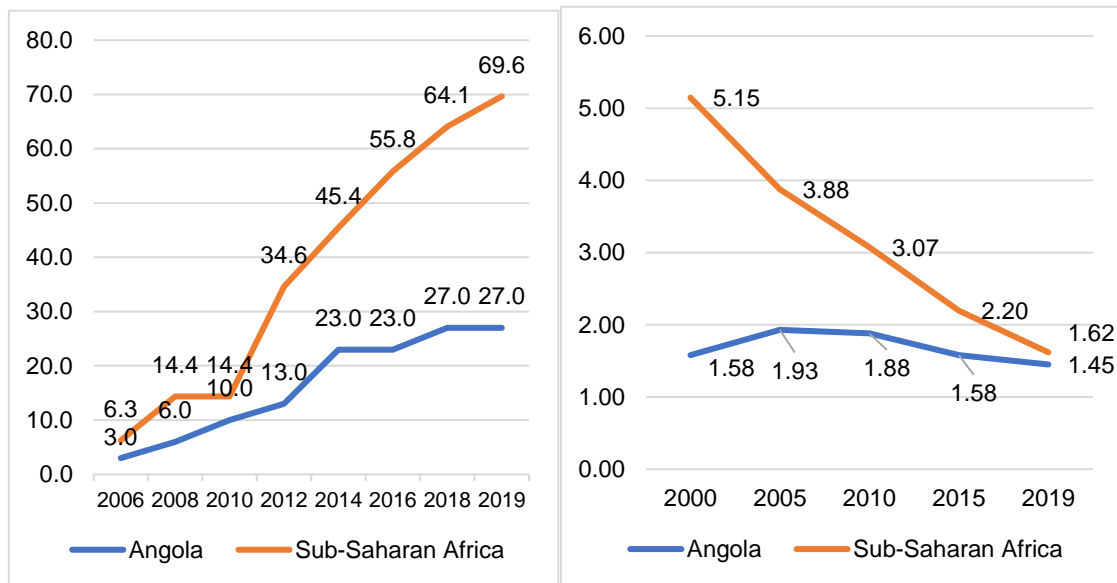


Figure 13: Trends in the Percentage of Antiretroviral Therapy Coverage (% of people Living with HIV) (left) and the Incidence of HIV, Ages 15–49 (per 1,000 uninfected population ages 15–49) (right)

Source: World Bank Open Data

(2) Malaria

Malaria is endemic throughout the 18 provinces of Angola. As mentioned in “1.1.2. Disease structure”, “neglected tropical diseases and malaria” account for 6% (2019) of deaths at all ages and is the 7th leading cause of death. Within the scope of this survey, we were unable to find data on the prevalence of the disease among all ages or adults in a national survey, but as shown in Table 14, the prevalence of malaria among children under five years of age is particularly high in the northeastern provinces of Cabinda, Uije, Malanje, Cuanza Norte, Lunda Norte, and Lunda Sul. The use of insecticide-treated mosquito nets is very effective in preventing malaria, but the use rate is less than 10% in some provinces. In Angola, mosquito nets are supposed to be provided free of charge at the time of the first antenatal care and at the time of pediatric checkups, but in many cases, health facilities do not have them in stock. As shown in Figure 14, the number of malaria cases has been increasing since 2010. According to interviews with the MoH officer, this may be related to an increase in the number of cases detected (an increase in the actual number of infected cases) due to an increase in the number of cases that can be diagnosed as a result of the widespread use of malaria rapid diagnostic kits, and an increase in the number of children who visit health facilities when they have a fever due to improved maternal education levels and access to health facilities.

The National Health Development Plan (PNDS) 2012–2025 identifies under-fives and pregnant women as important target population groups for malaria control. As described in

Section 1.1.4, “Maternal and Child Health,” malaria accounts for 9.2% (2015) of all deaths, especially among children under five. Malaria during pregnancy can cause miscarriages, premature births, low birth weight, anemia, and maternal deaths, and the WHO recommends at least three cycles of IPTp-SP treatment in pregnancy. However, in Angola, only 19.0% of pregnant women have received at least three doses of IPTp, and among the poorest, only 8.3%. One factor contributing to the low IPTp is stock-outs at health facilities. If the health facility does not have the medicine in stock, a health care provider writes a prescription and the pregnant woman is requested to go to a pharmacy to purchase it, but in some cases the medicine is not available due to financial reasons or because the pharmacy is also out of stock.²⁶ The National Development Plan (PDN) 2018-2022 aims to provide IPTp in all health facilities and to have “at least 50% of pregnant women receive four doses of IPTp by 2022”.

Table 14: Key Indicators for Malaria

Region	Province	Percentage who slept under an insecticide-treated net last night (%)	Percentage who received three or more doses of SP/Fansidar ²⁷	Prevalence of malaria in children under-five ²⁸
North	Cabinda	31.2	36.3	19.2
	Zaire	22.8	28.1	17.9
	Uige	21.9	10.4	31.2
North Central	Luanda	16.1	24.4	5.9
	Cuanza Norte	14.7	25.0	35.5
	Malanje	16.4	15.0	22.4
	Bengo	9.6	9.3	9.4
East	Lunda Norte	30.0	20.9	21.1
	Moxico	6.0	10.1	39.8
	Lunda Sul	30.2	21.5	9.0
South West	Cuanza Sul	19.0	18.0	26.2
	Benguela	16.2	20.3	9.7
	Namibe	25.1	13.7	1.0
South Central	Huambo	29.5	24.0	1.1
	Bié	21.6	8.3	32.6
	Huíla	8.6	9.4	2.1
South	Cuando Cubango	10.5	17.8	38.1
	Cunene	7.9	13.9	0.1
National Average			19.0	13.5
Rural			11.3	21.8
Urban			24.0	7.5
Wealth Quintile Lowest			8.3	20.8
Wealth Quintile Wealthiest			31.3	1.6

Source: Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016.

²⁶ Interviews with project staff of the Project for Improving Maternal and Child Health Services through the Maternal and Child Health Handbook

²⁷ Percentage of SP fixed dose/Fansidar received and administered

²⁸ Rates of Plasmodium falciparum or Plasmodium Vivax or both

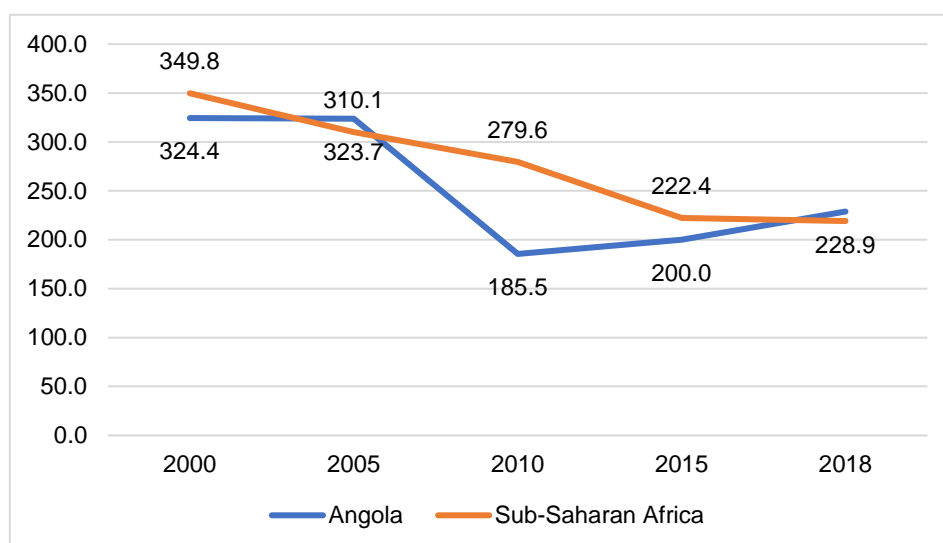


Figure 14: Incidence of Malaria (per 1,000 population at risk)

Source: World Bank Open Data

(3) Tuberculosis

The prevalence of tuberculosis (TB) in Angola is 355 (per 100,000 population: 2018), well above the sub-Saharan African average of 231 (2018), and this high prevalence continues. In its National Development Plan (PDN) 2018–2022, the Angolan government has set a goal of “achieving an 85% treatment success rate for TB cases by 2022.” However, after peaking at 72% in 2005, the treatment success rate has been declining in recent years, falling to 25% in 2017. The reasons for the decline in the success rate are not clear, but interviews with health care providers pointed out that it is difficult for TB patients to continue long-term treatment due to work and other social commitments, and many stop treatments due to TB stigma.²⁹ In addition, the Angolan government has not been able to prioritize TB services appropriately and relies heavily on the foreign funding. However, the non-fulfillment of commitments by the Angolan government has affected Global Fund grants, resulting in problems such as stock-outs of TB drugs from January 2017 to July 2018. In addition, there is low capacity for TB program implementation and low coverage of TB services and community outreach in the country. There is also a limited number of health facilities that can diagnose TB and very low capacity of the MoH to coordinate TB–HIV activities.³⁰

²⁹ Brady P, Vita D. Challenges to tuberculosis control in Angola: the narrative of medical professionals. *J Public Health (Oxf)*. 2018 Dec 1;40(4):820-826. doi: 10.1093/pubmed/fox159. PMID: 29186489.

³⁰ Global Fund Grants in the Republic of Angola

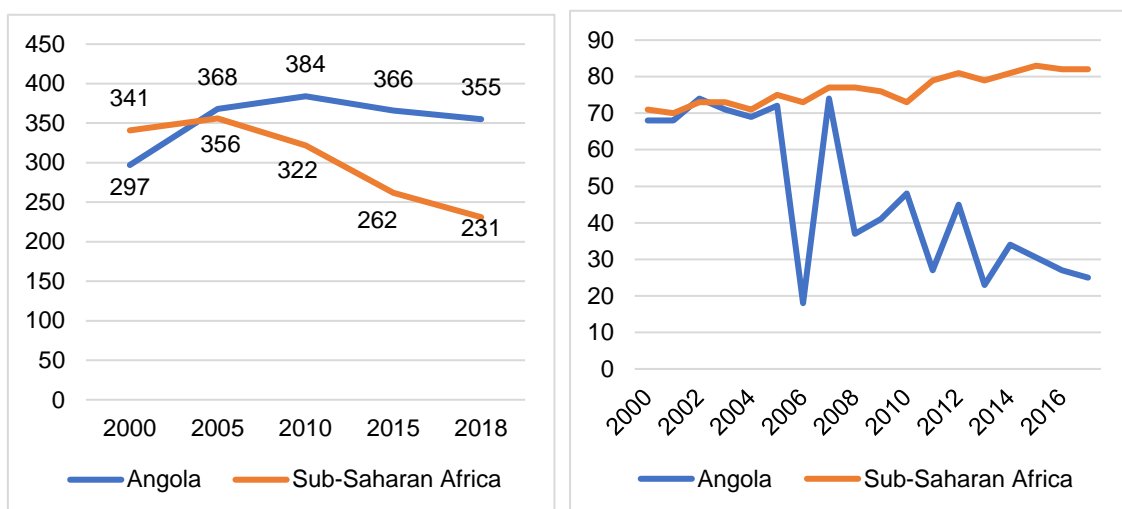


Figure 15: Incidence of tuberculosis (per 100,000 people) (left) and Tuberculosis treatment success rate (% of new cases) (right)

Source: World Bank Open Data

(4) Novel Coronavirus

On March 25th, 2020, the Angolan government declared a state of emergency, and on March 27, 2020, restrictions on movement came into effect. This measure was extended until April 25th, then shifted to a "State of Calamity" (easing the state of emergency) on May 25th, but the "restriction of movement" among provinces and other measures continued as of March 7th, 2021. As of March 7th, 21,055 novel coronavirus-positive cases had been announced, and 512 people had died. As of the same date, the number of infected people per week was 273, and the number of infected people per day has been hovering between 20 and 60.³¹ In case of suspected cases of COVID-19 or questions, people can call the hotline prepared by the government and not to go directly to health facilities to avoid confusion. On March 2nd, Angola became the first country in the Southern African region to receive 624,000 doses of COVID-19 vaccine from the COVAX initiative. Health care providers and citizens with underlying diseases will be vaccinated in the first phase.³² Masks are being worn in public places, large-scale events are being banned, and telecommuting is being encouraged. During the declaration of the state of emergency, health staff at health facilities also worked shifts, and some health facilities limited the number of patients they would accept.

2.1.6 Nutrition

With regard to malnutrition, the indicator of stunting (being too short for one's age), which

³¹ WHO COVID-19 Weekly Epidemiological Update; as of 7 March 2021

³² WHO Africa Angola becomes the first country in Eastern and Southern Africa region to receive COVAX vaccines against COVID-19

represents chronic malnutrition, has received much attention. In Angola, 37.6% of children are stunted, with large regional disparities, ranging from 31.8% in urban areas to 45.7% in rural areas. Although the exclusive breastfeeding up to six months is recommended to improve nutrition status, the duration (median) of exclusive breastfeeding in Angola is only 1.4 months, and the exclusive breastfeeding rate is 37.5%.³³ In addition, more than 60% of children under 5 years old are anemic. In the National Development Plan (PDN) 2018–2022, the goal is to have 80% of children with exclusive breastfeeding by 2022. According to the interview with the MoH, it is difficult to achieve exclusive breastfeeding because of the traditional habits (mothers were fed porridge by their mothers, there is a misconception that they have to give food to their babies after two weeks of birth and babies cannot grow up with only breast milk). Health education about exclusive breastfeeding is being conducted in antenatal care and community awareness activities.

Table 15: Key Indicators of Nutrition

Region	Province	Prevalence of stunting among children under 5 years of age	Percentage of children with anemia ³⁴	Average (median) duration of exclusive breastfeeding (in months)
North	Cabinda	21.6	65.8	–
	Zaire	24.9	69.7	–
	Uige	41.7	62.9	–
North Central	Luanda	29.7	66.8	1.4
	Cuanza Norte	44.5	53.9	–
	Malanje	31.9	70.3	0.8
	Bengo	39.7	64.4	–
East	Lunda Norte	38.7	68.4	–
	Moxico	38.5	75.4	–
	Lunda Sul	42.1	48.9	–
South West	Cuanza Sul	48.8	68.0	–
	Benguela	33.1	65.5	1.7
	Namibe	33.8	61.4	3.2
South Central	Huambo	43.6	53.6	2.3
	Bié	50.8	62.3	1.2
	Huíla	43.6	62.7	2.4
South	Cuando Cubango	42.9	77.0	–
	Cunene	39.3	65.5	3.1
National Average			64.8	1.4
Rural			65.2	1.5
Urban			64.5	1.3
Wealth Quintile Lowest			65.5	1.6
Wealth Quintile Wealthiest			62.9	1.6

Source: Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016.

2.1.7 Non-Communicable Disease

Non-communicable diseases (NCDs) are caused by factors such as smoking, lack of physical

³³ Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015-2016

³⁴ Percentage of hemoglobin below 11 g/dl.

activity, inadequate diet, and harmful intake of alcohol. As mentioned in section 1.1.2. “Structure of the disease”, the percentage of deaths caused by NCDs in Angola is increasing every year. It is estimated that 36% of all deaths are related to NCDs. The trends in mortality rates for cardiovascular diseases, neoplasms, diabetes, and chronic respiratory diseases are shown in Figure 16. All of them show the same increasing trend as in sub-Saharan Africa. The Angolan MoH points out that “NCDs are increasing exponentially, but the lack of knowledge among the population about the diseases and their risk factors, the double the burden of infectious diseases and NCDs and the consequent worsening of morbidity”,³⁵ and promoting health education about NCDs in school. The aim of the National Development Plan (PDN) 2018–2022 is for “50% of predefined schools to be screened for non-communicable diseases until 2022”.

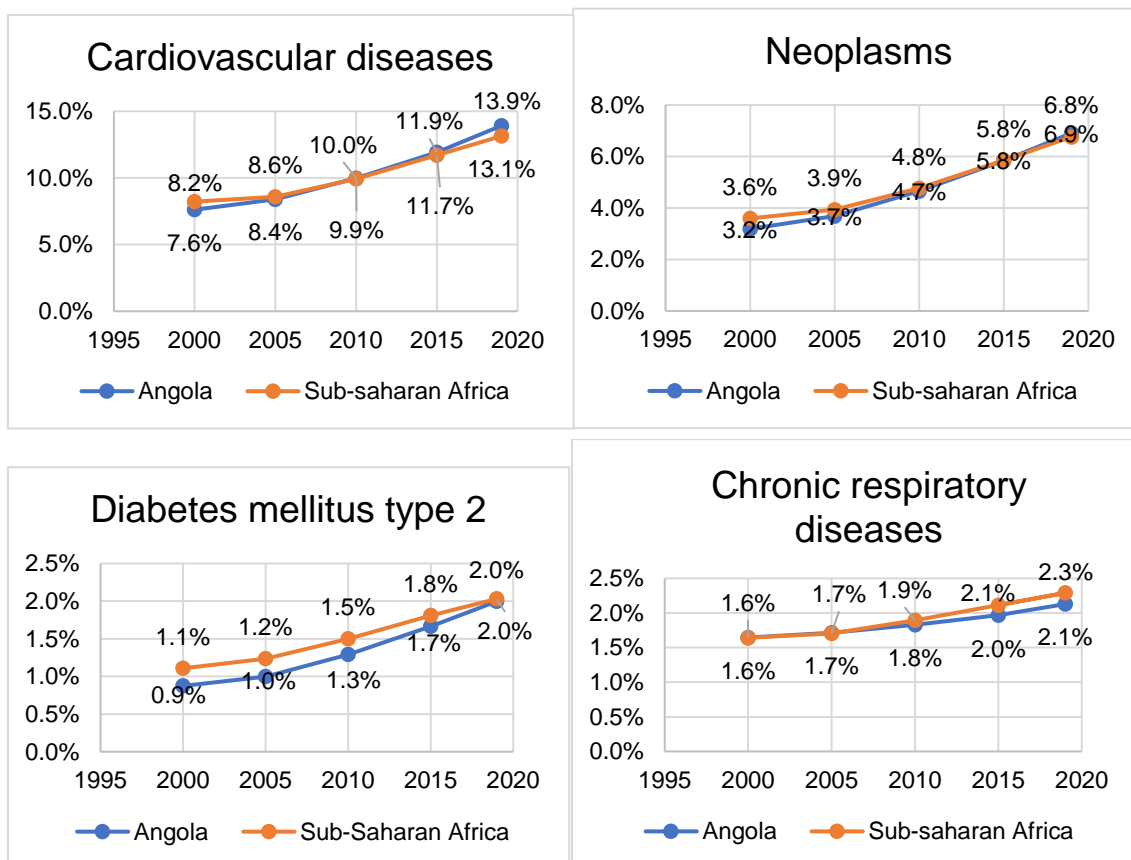


Figure 16 : Trends in Mortality Rates for Cardiovascular Disease, Neoplasms, Chronic Respiratory Disease, Diabetes Mellitus type 2

Source: Prepared by the survey team based on Institute for Health Metrics and Evaluation (IHME). GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington. Available from <http://vizhub.healthdata.org/gbd-compare>. (Accessed 2020.11.20)

Regarding alcohol consumption, which is important in the fight against NCDs, total alcohol

³⁵ National Development Plan (PDN) 2018–2022

consumption per capita (liters of pure alcohol, projected estimates, 15+ years of age) has recorded a decrease from 9.0 L/person in 2010 to 6.4 L/person in 2016.

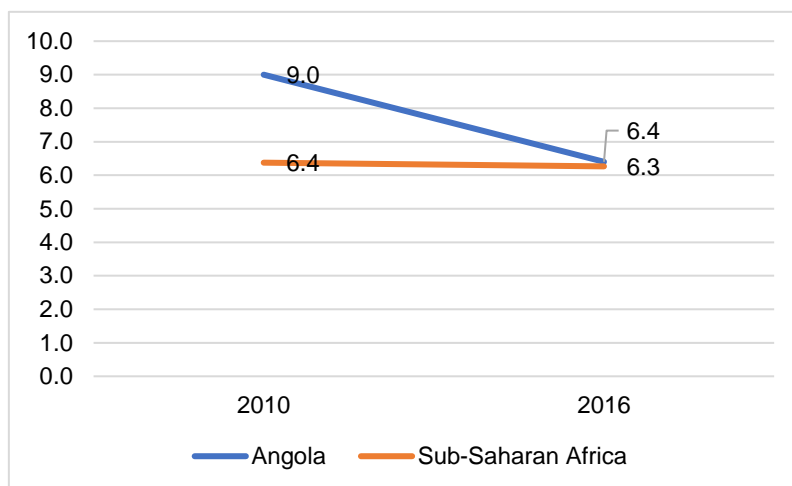


Figure 17: Total Alcohol Consumption per capita (liters of pure alcohol, projected estimates, 15+ years of age)

Source: World Bank Open Data

The current smoking rate in Angola for people over 15 years old is 14.3% for males and 1.8% for females. The percentage of daily smokers is 8.8% for males, and 1.0% for females. The average for sub-Saharan Africa is 10.17%³⁶, and Angola's rate is lower than the regional average.

Table 16: Smoking Rates and Frequency by Gender

	National average	Urban	Rural	Wealth Quintile Wealthiest	Wealth Quintile Lowest
Smoking rate (male)	14.3	11.7	20.9	9.8	21.1
Smoking frequency (daily, male)	8.8	6.6	14.5	4.9	13.9
Smoking rate (female)	1.8	1.3	2.9	1.3	3.4
Smoking frequency (daily, female)	1.0	0.5	2.1	0.2	2.6

Source: Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016.

2.2. National Development Plans and Related Policies and Plans in the Health Sector

2.2.1. National Development Plan

Angola 2025 (Estratégia de Desenvolvimento a Longo Prazo Para Angola [2025]), a long-term development policy to achieve sustainable development in Angola, aims to “free the country

³⁶ World Bank Open Data, 2016

out of poverty by promoting economic growth, economic stability, and employment”.

Based on Angola 2025, the Angolan government has formulated the PDN (Plano de Desenvolvimento Nacional) as a medium-term strategy. The latest PDN was formulated in April 2018 (PDN 2018-2022). The strategy has six main goals and 25 strategic policies: 1) Human Development and Welfare, 2) Sustainable, Diversified and Inclusive Economic Development, 3) Infrastructures Necessary for Development, 4) Consolidation of Peace, Strengthening of the Democratic and Rule of Law, Good Governance, State Reform, and Decentralization, 5) Harmonious Development of the Territory, and 6) Guarantee of Angola’s Territorial Stability and Integrity, and Strengthening its role in the International and Regional context. In terms of health policy, it aims to “fight poverty and promote the sustained improvement of the health status of the Angolan population, supporting, in a more direct way the most disadvantaged and poor social groups, ensuring the population a longer healthy longevity”, with the following priorities for intervention:

1. Improvement of Medical and Medicinal Assistance
2. Improving Maternal and Child Health and Nutrition
3. Combating Major Endemics by Addressing Health Determinants
4. Strengthening of the Health Information System and Development of Health Research

For each of the priorities, targets are set to be achieved by 2022.

2.2.2. Position of the Health Sector in National Development Plans

The Angolan government has promulgated the National Health Development Plan (Plano Nacional de Desenvolvimento Sanitário: PNDS [2012-2025]) as a priority policy for the health sector. This policy was formulated in response to the Presidential Decree, and its important issues are in line with policies such as the long-term development strategy “Angola 2025”, making it a strategic operation tool. The vision of the PNDS is to “promote fulfillment of the right to health enshrined in the Constitution”, “promote increased life expectancy at birth”, “reduce maternal, infant and child mortality and morbidity”, and “improve the human development index” etc., for the sustainable development of each sector. PNDS 2012–2025 is subdivided into 9 programs, 20 sub-programs, and 58 projects. The overview and priority programs are shown in Table 17 and Figure 18.

Table 17: National Health Development Plan (PNDS) 2012–2025 Overview

Objective	<ul style="list-style-type: none"> • Improve the provision of quality health care, in terms of promotion, prevention, treatment, and rehabilitation, as well as strengthening the link between primary care and hospital care • Operationalize the provision of health care at the community level and at each of the three levels of the health pyramid, meeting the expectations of the population
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	<ul style="list-style-type: none"> • Improve the organization, management, and functioning of the National Health System (NHS), by allocating the necessary resources and adopting rules and procedures that increase the efficiency and quality of the responses of the NHS • Participate in the transformation of social determinants of health and promote national and international partnerships, in favor of reducing maternal and child mortality and programs to combat major endemic diseases • Monitor and evaluate the implementation of the PNDS, including the sector’s performance, through the health information system and special studies • Serve as a basis for reviewing and adapting the National Health Policy in 2018 and 2026 (no review was conducted in 2018)³⁷
<p>Key Guiding Strategies</p>	<ol style="list-style-type: none"> 1. Organizing levels of care, ensuring continuity and integration, under the coordination of the National Health Service 2. Improving the quality of care and services, in each structure and at each level 3. Strengthening control of endemic diseases and epidemiological surveillance 4. Introduction of new operational strategies for health promotion, prevention, and early detection of chronic diseases at the primary care level, with a focus on screening for hypertension, diabetes, and cancer 5. Promotion of individual and collective protection measures 6. Significantly expand the quantity and quality of human resources in the health sector 7. Expanding health networks through provincial Health Maps 8. Ensure availability of essential drugs, medicines, and medical devices 9. Regular and systematic production of information for evidence-based management of the NHS 10. Introduction of new technologies 11. Promotion of health research 12. Allocation of more financial resources to the sector and better planning and use 13. Adaption of the legal and regulatory framework of the health sector to the changes anticipated in the reform 14. Contribution to positive transformation in the social determinants of health to reduce health inequities 15. Mobilization and coordination of national and international partnerships 16. Monitoring and evaluation of PNDS, projects, and sector performance

Source: National Health Development Plan (PNDS) 2012–2025

³⁷ Interview with MoH officer



Figure 18: Nine Programs in the National Health Development Plan (PNDS) 2012–2025

Source: National Health Development Plan (PNDS) 2012–2025

2.3. Status of Other Donors' Support in Angola

2.3.1. Assistance Achievements

In the area of health in sub-Saharan Africa, the United States is the leading bilateral aid donor (\$8.7 billion), compared to the United Kingdom (\$4.2 billion), Canada (\$2.4 billion), and Japan (\$1.2 billion) in 2009–2018.³⁸ In Angola, the U.S. ranked first (\$289.47 million), far ahead of Portugal (\$12.71 million) and Japan (\$11.27 million), which ranked second and third, respectively. In addition, Portugal, the former sovereign nation of Angola, stands out prominently on the list. China has shown a significant presence, for example, by providing early assistance in the fight against the new coronavirus, however, it is not a member of the OECD's Development Assistance Committee (DAC) and is not included in this analysis.

From 2009–2018, international organizations have provided aid to the health sector in sub-Saharan Africa, with \$11.4 billion from the Global Fund, \$6.7 billion from GAVI, and \$4.9 billion from the World Bank. In Angola, it followed a similar trend with regards to the order of amount of assistance: \$108.58 million from the Global Fund, \$81.40 million from GAVI, and \$1.15 million from the World Bank. Based on the classification method used by OECD.Stat, the number of donors supporting health policy and administration, malaria control, communicable disease control, and basic health services is high, and the amount of aid to malaria control is high. At present, no donors have been found to provide large-scale support for medical education and

³⁸ OECD.Stat

training, health human resource development, and basic health infrastructure.

Table 18: Top Aid Donors in the Health Sector (Total Amount, 2009–2018)

Classification	Rank	Name of country/institution	Amount (Millions of dollars)
Bilateral	1	United States of America	289.47
	2	Portugal	12.71
	3	Japan	11.27
	4	Spain	7.55
	5	Italy	4.35
	6	The United Kingdom	3.98
	7	Norway	1.28
	8	France	0.95
	9	Germany	0.83
	10	Canada	0.24
International organization	1	Global Funds	108.58
	2	GAVI	81.40
	3	EU	42.26
	4	WHO	16.88
	5	UNICEF	5.91
	6	World Bank	1.15
Private institution	1	Bill & Melinda Gates Foundation	13.33
	2	World Diabetes Foundation	0.34

Source: Prepared by the survey team from OECD.Stat

Table 19: Areas of Cooperation of Development Partners in Angola (2009–2018)³⁹
(Up to about \$5 million is listed, units in millions of dollars)

	Health policy and administrative management	Medical education and training	Health personnel development	Medical Research	Medical care Services	Basic health care	Basic health infrastructure	Basic nutrition	Health education	Infectious disease control	Malaria control	Tuberculosis control
Donor	WHO: 8 EU: 8 United States: 6 Spain: 5			Portugal: 6	Portugal: 5	GAVI: 81 EU: 29		United States: 20		BMGF: 9 United States: 8	USA: 254 GF: 88 BMGF: 5	GF: 21

Note: ADF: African Development Fund, BMGF: Bill & Melinda Gates Foundation, GF: Global Fund to Fight AIDS, Tuberculosis and Malaria, WB: World Bank, WHO: World Health Organization, EU: European Union

Source: Prepared by the survey team from OECD.Stat

³⁹ The classification of cooperation areas is based on the DAC and CRS code lists used by the OECD. The detailed information; <http://www.oecd.org/dac/financing-sustainable-development/development-finance-standards/dacandcrscodelists.htm>

(1) Bilateral Cooperation #1: United States of America

The amount of U.S. bilateral cooperation is more than any other country, where the main focus is on malaria control, and has provided over \$20 million in aid each year. The major projects by the U.S. are as follows:

- Malaria control : Deliver Project for Malaria (2012–2016, \$45.25 million) / Global Health Supply Chain - Procurement and Supply Management (2016–2018, \$18.57 million) / Integrated Health Social Marketing (2011–2016, \$15.62 million) / Strengthening through Health Service Delivery and Technical Activities (2011–2017, \$31.84 million) / Health for All project (2017–2018, \$21.00 million)

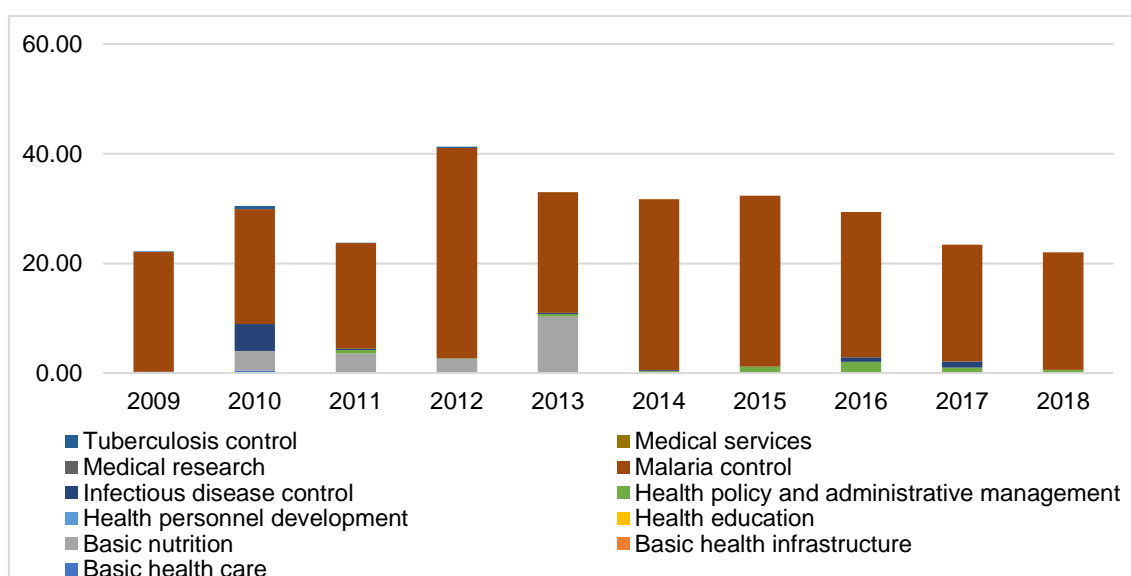


Figure 19: U.S. Support to Angola Health Sector (US\$ million)

Source: Prepared by the survey team from OECD.Stat

(2) Bilateral Cooperation #2: Portugal

Portugal is the former sovereign state of Angola and the second-largest source of bilateral cooperation with Angola. The main focuses of aid were medical research and medical services, but since 2016, there has been a sharp downward trend. In 2018, aid to health services accounted for a large share of the total. The major projects by Portugal are as follows:

- Medical services: patient’s evacuation (2010–2017, \$4.39 million)
- Medical Research: Support for the creation of a health research center in Angola (2009–2015, \$5.27 million)

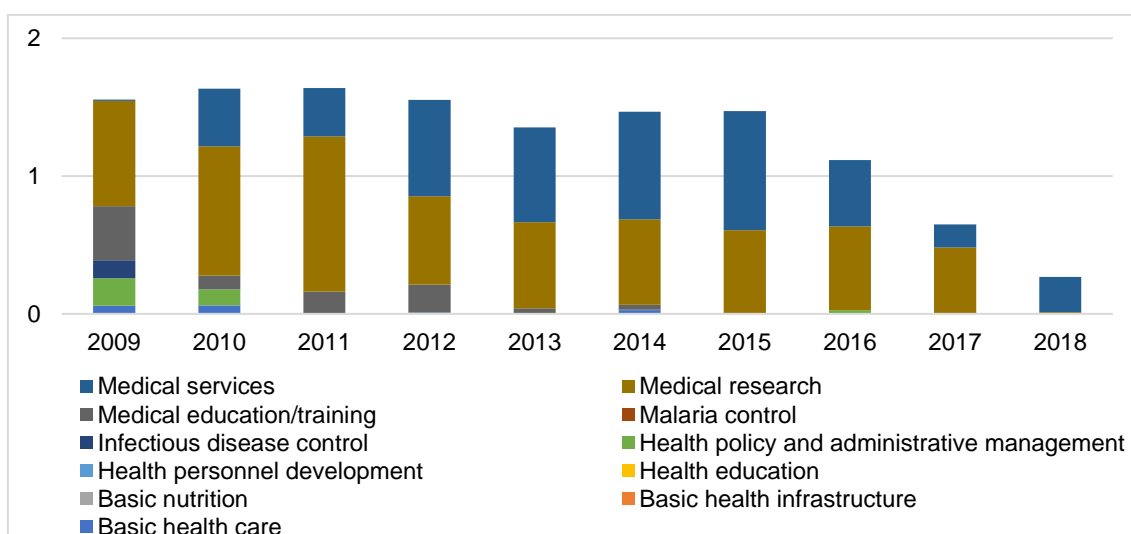


Figure 20: Portuguese’s Support to Angola Health Sector (US\$ million)

Source: Prepared by the survey team from OECD.Stat

(3) Other Bilateral Cooperation: Brazil

Under the Japan-Brazil Partnership Program (JBPP), signed in 2000 by the governments of Japan and Brazil, both countries are jointly implementing a triangular cooperation with Angola, which formally initiated the “Project for Strengthening the Health System through Human Resources Development and Revitalization of Primary Health Care in the Josina Machel Hospital and Other Health Institutions (ProFORSA) (2011–2014). The results of the project were introduced as a successful example of triangular cooperation at the Global South-South Development Expo 2014. In addition, a third country training course on “Humanized Childbirth” was started in 2016 (this was scheduled to end in 2020, but is extended for one year due to the COVID-19 pandemic). More than 60 people participated, and the Sofia Feldman Hospital in Brazil accepted the participants. The Agencia Brasileira de Cooperação Internacional (ABC) is covering part of the costs.

In December 2019, an evaluation mission from ABC and Sofia Feldman Hospital came to Angola to evaluate the third country training, which was also attended by Mozambicans who had participated in the third country training on “Humanized Childbirth”. On this occasion, the JICA Angola Office organized a “Maternal and Child Health Seminar”, which was also attended by people involved in the “Project for improving maternal and child health services through the implementation of the Maternal and Child Health Handbook”, which currently being implemented in Angola. The staff of the Angolan MoH was very much impressed by Mozambique’s presentation on the “Humanized Childbirth” initiative, which included specific proposals such as “incorporating humanization training into all health-related training”, and

“holding seminars with provincial governors and mayors”.⁴⁰

(4) Multilateral Organization #1: Global Fund

The Global Fund is the number one aid donor in the multilateral organization, and while malaria control has consistently been the main focus, the proportion aid for tuberculosis control has been increasing. In 2018, 250,000 copies of the Maternal and Child Health Handbook were printed and utilized through a Global Fund technical cooperation project with Japan. Some of the projects by Global Fund in Angola are as follows:

- Malaria control: Universal Access to Malaria Prevention and Treatment in Angola (2012–2018, \$43.28 million) / Scaling Up Malaria Interventions in Angola (2009–2012, \$22.15 million)

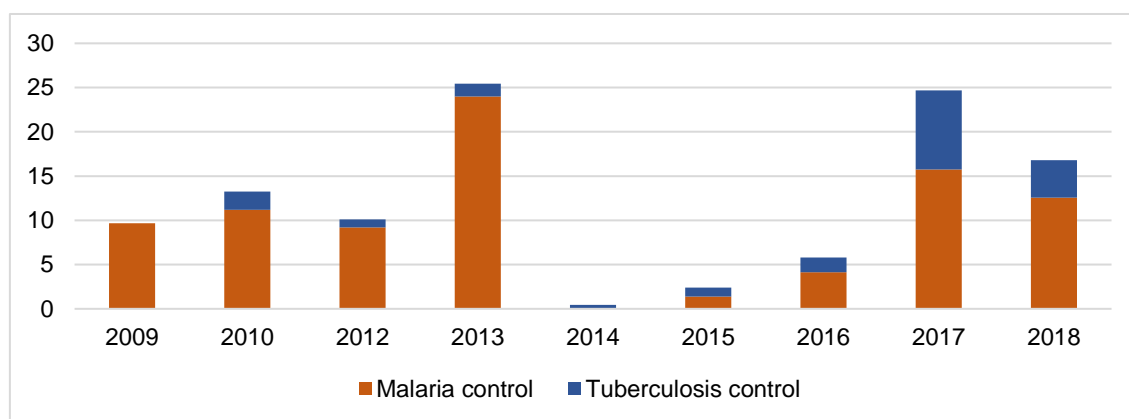


Figure 21: Global Fund’s Support to Angola Health Sector (US\$ million)

Source: Prepared by the survey team from OECD.Stat

(5) Multilateral Organization #2: GAVI the Vaccine Alliance (GAVI)

Assistance with basic health care (vaccinations) is provided annually, such as the following:

- Basic health care - New vaccine support (NVS) (2010–2018, \$66.13 million)

⁴⁰ Interviews with project staff of the Project for Improving Maternal and Child Health Services through the Maternal and Child Health Handbook.

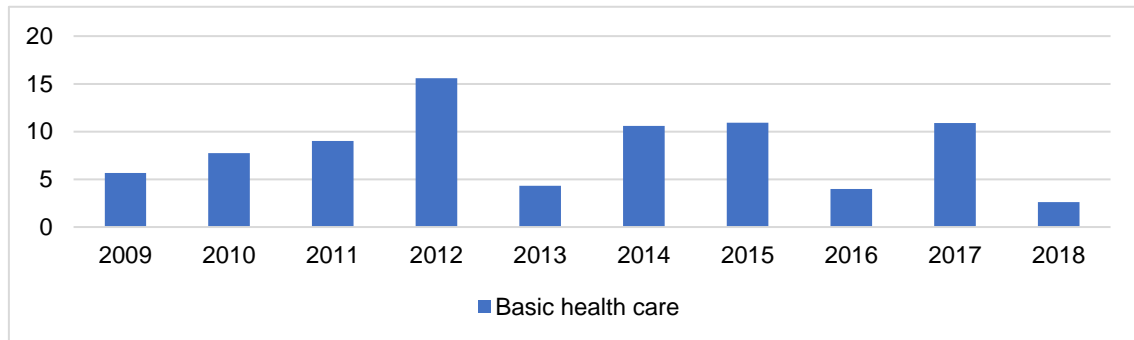


Figure 22: GAVI's Support to Angola Health Sector (US\$ million)

Source: Prepared by the survey team from OECD.Stat

(6) Multilateral Organization #3: EU

In the Provision of technical assistance service to support the health sector II (Prestação de serviço de assistência técnica para apoio ao sector da saúde II [PASS II]), 300,000 Maternal and Child Health Handbooks were printed and utilized through an EU technical cooperation project with Japan.

- Provision of Technical Assistance Service to Support the Health Sector II (2013–2018, \$13.50 million)

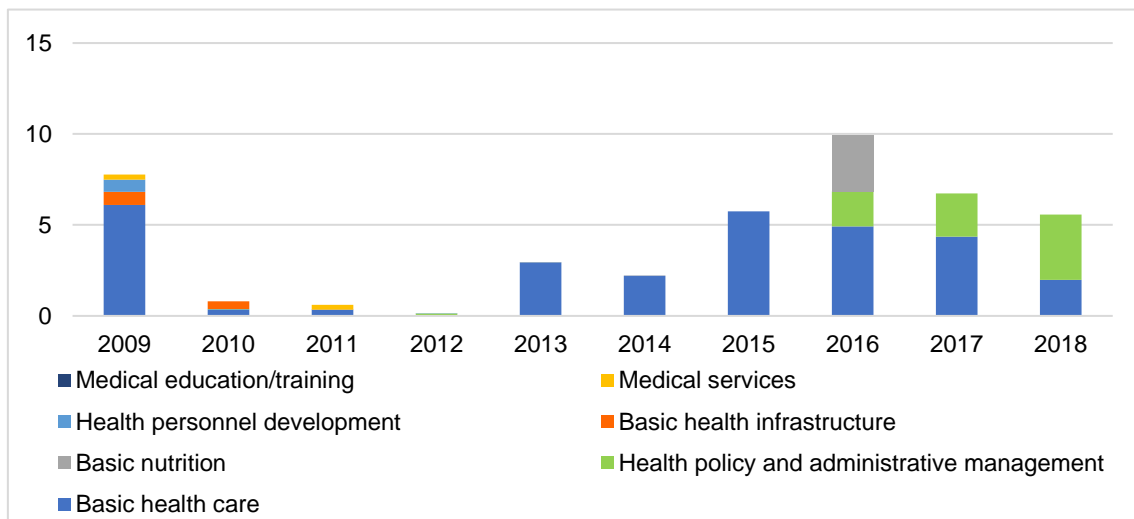


Figure 23: EU's Support to Angola Health Sector (US\$ million)

Source: Prepared by the survey team from OECD.Stat

(7) Private Sector No. 1: Bill & Melinda Gates Foundation

The number one private sector donor is the Bill & Melinda Gates Foundation. The

foundation’s main focus has been on infectious disease control, but from 2017, it shifted its focus from infectious disease control to malaria control. Here are some of the projects:

- Malaria control : Southern Africa Malaria Elimination Eight Initiative Secretariat (2017, \$3.80 million)
- Infectious disease control : World Vision (2009–2014, \$2.79 million) / UNICEF Headquarters (2009–2012, \$5.72 million)

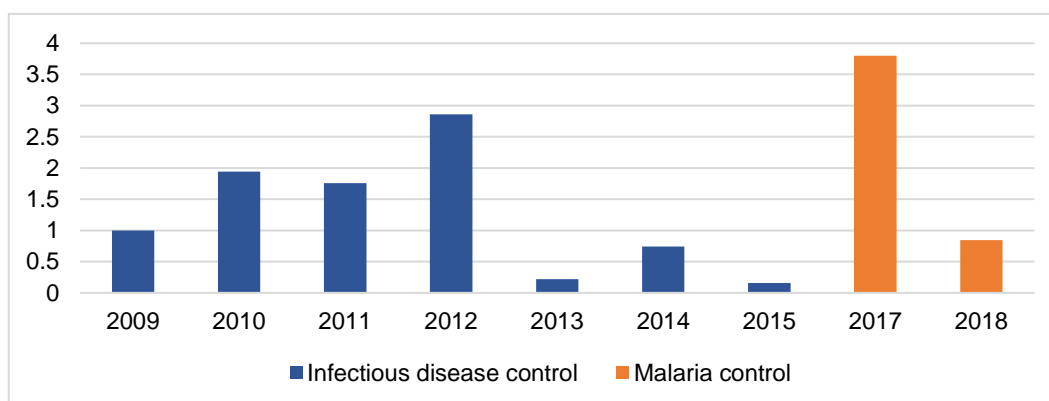


Figure 24: BMGF’s Support to Angola Health Sector (US\$ million)

Source: Prepared by the survey team from OECD.Stat

2.3.2. Activities

(1) World Health Organization (WHO)

WHO’s Cooperation Strategic Agenda (2015-2019) identifies four priority strategies: 1) Health system strengthening, 2) Improving maternal, adolescent and child health, 3) Disease control, and 4) Preparation, surveillance, and response to epidemic outbreaks and emergencies. Each priority strategy and initiatives for support are listed in Table 20.

Table 20: WHO Country Cooperation Strategy (2015–2019)

Strategic Priorities	Main Focus Areas for WHO Cooperation
STRATEGIC PRIORITY 1: Health system strengthening	<p><u>Organization and management of health systems</u></p> <ul style="list-style-type: none"> • Development of standards and procedures for organizing the network of services • Establishment of levels of referral and counter-referral for pathologies and development of administrative support subsystems, under the strategy for decentralization and municipalization of health services • Assessment of the impact of the health services municipalization process on community access to and use of health care and services • Development of a national health promotion strategy • Development of a policy for community participation in health • Conduct of studies on the cost of health services, including a periodic report on health accounts
	<p><u>Development of human resources</u></p> <ul style="list-style-type: none"> • Finalization of the National Human Resources Policy and Strategic Plan, including dissemination and advocacy for implementation as well as the mobilization of partners

	<ul style="list-style-type: none"> • Structuring and naming of the different health professions • Updating and periodical revision of initial and specialized training curricula for the health sciences in accordance with international standards • Development of strategic plans and accreditation of training schools for health technicians and higher teacher-training and certification institutes • Development of further training programme packages to be distributed to training schools for health technicians, permanent training centres and the National Public Health School, with a view to institutionalizing skills development courses in services related to priority health programmes • Establishment and constant update of national and provincial human resource observatories, and linkage of such observatories with virtual libraries and telemedicine programmes for health professionals • Reproduction of Blue Trunk Library packages for distribution to municipalities <p><u>Health System strengthening and health research</u></p> <ul style="list-style-type: none"> • Implementation of the Health Information System Strategic Plan (PESIS) • Design of an integrated, simple, user-friendly health information system, at all levels • Technical capacity-building for Planning and Statistics Studies Cabinet (GEPE) professionals to ensure the management, update and adjustment of the information system • Establishment of a committee of experts to analyse, validate and publish health information • Preparation of a draft Health Research Strategy and definition of a national research agenda • Support for the establishment of ethics committees in institutions • Technical assistance for the design and implementation of a population and health survey and other surveys for priority population groups • Publication and dissemination of the findings of national health surveys <p><u>Medicines, medical supplies and equipment</u></p> <ul style="list-style-type: none"> • Preparation of the national essential medicines and medical supplies list • Enhancing the reliability of the procurement system for medicines and medical supplies • Introduction of software for managing essential medicines • Technical assistance to Central Medical Stores (CECOMA) to build sustainable capacity for the logistical management • Strengthening the quality control system through the installation and operationalization of the national quality control laboratory for medicines and the pharmacovigilance network (reporting and management of adverse events) and safe blood transfusion • Development of a system for recording and approving the introduction of medicines and medical supplies into the market <p><u>Network of health laboratories</u></p> <ul style="list-style-type: none"> • Technical capacity-building for the laboratory staff of the National Public Health Institute (INSP) • Development and implementation of the National Health Laboratories Policy • Accreditation of laboratories for diagnosis of measles, yellow fever, HIV, malaria and tuberculosis <p><u>Support the implementation of the strategy of ADECO's (Community Development Agents)</u></p>
<p>STRATEGIC PRIORITY 2: Improving maternal, adolescent and child health</p>	<ul style="list-style-type: none"> • Revision and updating of the National Reproductive Health Policy • Support to improve quality of care for women, newborn, children and youth/adolescents • Development of comprehensive communication and advocacy plans on women's, children's health and adolescents with emphasis on repositioning of family planning (FP)
<p>STRATEGIC PRIORITY 3: Disease control</p>	<p><u>Infectious disease</u></p> <ul style="list-style-type: none"> • Drafting/updating of national policies • Dissemination of innovative strategies and methodologies for the prevention and control of priority • Support elaboration of strategic plans for the procurement, quality control, distribution and proper use of medicines • Implementation of capacity-building for communicable diseases control at community level <p><u>NCDs</u></p>

	<ul style="list-style-type: none"> · Development, monitoring and evaluation of the National strategic plan for the control and prevention of non-communicable diseases (NCD) under the 2012–2025 NHDP. · Preparation and dissemination of technical guidelines and training manuals for better treatment of NCDs · Capacity-building in NCDs for health professionals · National capacity-building for the promotion of healthy lifestyles
STRATEGIC PRIORITY 4: Preparation, surveillance and response to epidemic outbreaks and emergencies	<ul style="list-style-type: none"> · To update the National Strategic plan for integrated disease surveillance · Implementation of the Integrated Disease Surveillance and Response (IDSR) human resource plan · Continuation of capacity-building as required by International Health Regulation (IHR 2005) · Development of an epidemic and disaster risk management policy and strategy · Evaluation of national capacity for risk management, risk mapping, strengthening of early warning mechanisms, preparation and appropriate response to emergencies and disasters at the provincial level and in areas on the border with neighboring countries

Source: WHO, Country Cooperation Strategy (2015-2019)

(2) World Bank (WB)

The WB has 2 main projects in the health sector:

1. Health System Performance Strengthening Project (HSPSP); from March 2018 to September 2023

Project Objective: to increase the utilization and the quality of health care services in target provinces and municipalities

2. Regional Disease Surveillance Systems Enhancement Project (REDISSE) Phase IV; from October 2019 to July 2024

Project Objectives:

- i. To strengthen national and regional cross-sectoral capacity for collaborative disease surveillance and epidemic preparedness in the Participating Countries (Angola, Chad, RDC, Congo, Central Africa)
- ii. In the event of an Eligible Crisis or Emergency, to provide an immediate and effective response to said Eligible Crisis or Emergency

(3) Global Fund (GF)

The Global Fund has cumulatively invested around \$US300 million in Angola since 2004 but according to the “Audit Report; 12th February 2020”, the Global Fund grants in Angola are performing poorly. Grant performance suffers from a combination of multiple issues, including weak country ownership, government failure to fulfill domestic commitments, unreliable data, and ineffective management structures in the MoH. These issues have persisted in the country since the last audit in 2012, with limited or no progress in addressing them. As a result, Global Fund grants in Angola have achieved limited programmatic impact, with no improvements in both mortality and morbidity across all three diseases (HIV/AIDS, malaria, and tuberculosis). This raises significant strategic questions around the role of Global Fund grants in this operating environment, and the need to develop new approaches to engaging with

the country.⁴¹

(4) USAID

Through the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI), USAID supports the MoH to develop, strengthen, and sustain Angolan health systems to reduce the spread of malaria and HIV/AIDS and other communicable diseases. USAID focuses on strengthening universal access to high-quality voluntary family planning services and reproductive health care.

USAID has 4 main projects in Global Health sector.

1. Reducing Infections through Support and Education II (RISE II); from October 2019 to September 2022

The RISE II activity is a regional award that contributes to global goals of ending the HIV/AIDS epidemic by 2030, and improves community health and wellbeing across Southern and Eastern Africa. Among its activities include:

- Routine education on HIV/TB services, Malaria, and Non-Communicable Diseases
- Supporting treatment adherence, retention, and early infant diagnosis for HIV exposed infants⁴²

2. Health for All; from January 2017 to January 2022

The project provides targeted, evidence-based interventions in the areas of malaria and family planning (FP) and reproductive health. HFA's overarching goal is to improve access to quality health care services for the Angolan people by strengthening the Angolan government's capacity to deliver these services. Among its focuses and activities include:

Malaria:

- Train health workers to effectively diagnose and treat malaria cases
- Train technicians on intermittent preventive treatment of malaria in pregnancy using sulfadoxine-pyrimethamine as well as on case management during pregnancy
- Improve Angola's health information system for malaria surveillance and reporting by consolidating the use of the DHIS2 platform
- Support and expand the community development agent (ADECOS) program in three PMI focus provinces

⁴¹ Audit Report; Global Fund Grants in the Republic of Angola, 27 February 2020

⁴² REDUCING INFECTIONS THROUGH SUPPORT AND EDUCATION II (RISE II): <https://www.usaid.gov/angola/fact-sheets/reducing-infections-through-support-and-education-ii-rise-ii>

Family Planning and Reproductive Health:

- Support the Reproductive Health Department of National Public Health Department to expand Family Planning long-term methods via capacity building
- Improve FP and RH services, with a focus on youth⁴³

3. Global Health Supply Chain Procurement & Supply Management; from September 2016 to September 2021

This program works to reduce costs and increase efficiencies in global and national supply chains. Its overriding purpose is to ensure the uninterrupted supplies of health commodities. Technical assistance to the Angolan government focuses primarily on support to the MoH and the Central Procurement Agency for Medicines and Medical Supplies Central Medical Store (CECOMA). Among its activities include:

- Undertake strategic planning and implementation of supply chain management tasks
- Build capacity for implementing strategies to transfer skills, knowledge, and technology for improved supply chain performance
- Share and assist with the implementation of the latest innovations⁴⁴

4. Demographic and Health Survey - DHS 2020 from January 2018 to June 2023

The USAID's Demographic and Health Surveys (DHS) project in collaboration with the National Institute of Statistics (INE) and the MoH in Angola will implement the population-based health survey, entitled "Inquérito de Indicadores Múltiplos e de Saúde (IIMS)". Among its focuses and activities include:

- Conduct the 2020 Demographic and Health Survey⁴⁵

(5) UNICEF

UNICEF programs in the country are in accordance with the 2015-2019 Cooperation Program signed with the Government of Angola and based on the country's National Development Plan (PDN). The overall objective of the UNICEF Cooperation Program is to support government efforts to reduce disparities in the social indicators of Angola's child population.

⁴³ HEALTH FOR ALL (SAÚDE PARA TODOS): <https://www.usaid.gov/angola/fact-sheets/health-all-sa%C3%BAdede-para-todos>

⁴⁴ GLOBAL HEALTH SUPPLY CHAIN PROCUREMENT & SUPPLY MANAGEMENT: <https://www.usaid.gov/angola/fact-sheets/global-health-supply-chain-procurement-supply-management>

⁴⁵ DEMOGRAPHIC AND HEALTH SURVEY - DHS 2020: <https://www.usaid.gov/angola/fact-sheet/linkages>

1. Child Survival and Development Program

The aim is to contribute to the reduction of maternal and child mortality in Angola and to support the planning, implementation, monitoring and evaluation of interventions, as well as the creation of models for replication and expansion purposes. To this end, the program has four key areas of action:

Maternal and Child Health sub-program:

- Promotion of the quality standards of neonatal care, aligned with the Action Plan for All Newborns.
- Revitalization of the Community Health Agenda through the ADECOS program and other existing platforms.
- Strengthening routine immunization and cold chain management at the central and provincial levels.
- Assistance to the MoH to strengthen a health system that is resilient and responsive to emergencies.

Nutrition:

- Training of more health professionals in integrated clinical management and quality of care of cases of Severe Acute Malnutrition and medical complications
- Provide more community workers and health centers with appropriate anthropometric tools to track and monitor children's weight and height
- Promoting breastfeeding and complementary feeding through mother-to-mothers' counselling groups at church and community level and through Development Communication campaigns for social behavior change

Vaccination:

- Training of health and logistics personnel in the installation of cold chain equipment
- Financing and expansion of routine immunization activities in target municipalities to increase access to and demand for immunization services

HIV:

- Analysis of bottlenecks of PMTCT services and pediatric antiretroviral treatment at the municipal and health unit level and preparation of corrective action plans
- Technical support for the review of the National Strategic Plan with a component of PMTCT and pediatric treatment

Other programs such as water, sanitation and Hygiene, Education, Child Protection, Social Policies, are also being implemented.⁴⁶

⁴⁶ <https://www.unicef.org/angola/o-que-fazemos-em-angola>

2.3.3. Achievements and Current Status of Japan’s Cooperation to Date

In Japan’s Country Development Cooperation Policy for Angola, Japan has set “sustainable economic development and human security” as a basic policy of the Japanese Official Development Assistance (ODA). The main areas of focus are: 1) support for economic development with the aim of industrial diversification, 2) development of diverse human resources, and 3) support in the field of human security. The health sector is included in 3) support for human security, and the government has stated that it will contribute to the achievement of the SDGs by improving health services and supporting the promotion of public health. The main assistance in the health sector to date is shown in Table 21. In addition, the grant aid “Josina Machel Hospital Improvement Project” was implemented in 2002 with a cost of about 4 billion yen. In the first phase of the project, Japan supported the renovation of the surgical ward and the construction of the mechanical and electrical buildings. In the second phase, Japan supported the renovation of the internal medicine ward, the construction of the central medical department and the outpatient building, and the provision of medical equipment such as operating tables, anesthesia machines, and endoscopes.

Table 21: Japan’s Major Assistance in the Health Sector over the Past Decade

Scheme	Period of cooperation	Name
Grant Aid	2011	Water Purification System Improvement Project in Kindenuco Village, Uije Province
	2010-2011	The Project for Equipment Renovation of Viana Vocational Training Center
	2010	Polio Eradication Programme (UNICEF collaboration)
	2009	National Mine Removal Institute Capacity Advancement Program
	2008	Childhood Infectious Disease Control Plan for the Republic of Angola (via UNICEF)
Technical Cooperation Projects	2018 - present	Project for Improving Maternal and Child Health Services through Implementation of the Maternal and Child Health Handbook (Phase 2)
	2017-2018	Project for Improving Maternal and Child Health Services through Implementation of the Maternal and Child Health Handbook (Phase 1)
	2011-2014	Project for the strengthening of the health system through human resource development at Josina Machel Hospital and other health services and revitalization of primary health care in Angola
	2010-2013	Josina Machel Hospital Human Resource Development Enhancement Project
Grassroots Technical Cooperation Projects	2016	Landmine Clearance Project in Urambo Province
	2016	Benguela General Hospital Cataract Surgical Unit Installation Plan
	2014	Wheeler State Minefield Identification Study Plan
	2014	Expansion of Don Elizeu Health Center, Luanda Province
	2014	Water Purification System Improvement Project in Kindenuco Village, Uije Province
	2013	Plan for construction of emergency ward at Chiullo Catholic Hospital, Kunene Province
	2013	The city of Lushazes, Province of Moshiko, Mine Clearance Plan
	2012	Project for the construction of a health education center in Velas, Luanda

	2011	Plan for the construction of a health center in Luena, Moxico
	2010	Preventive Health Care System Development Plan for XANGO District, Viana, Luanda Province

Source: Official Development Assistance (ODA) Country Data Book, Ministry of Foreign Affairs of Japan

3. Current Status and Challenges of Health Systems in Angola

3.1. Health Human Resources

3.1.1. Current Status of Health Human Resources

There are four major categories of health human resources working in the public sector, as shown in Table 22, each of which is described in detail in the Official Gazette of the Angolan Government.⁴⁷ Figure 25 shows the number of human resources in each category: as of 2011, there were 3,541 doctors, 34,301 nurses, 6,414 technicians (DTT: Diagnostic or Therapeutic Technicians), and 9,640 other staff (clerks, cleaning staff, etc.).

Table 22: Categories of Human Resources for Health in Angola

<ul style="list-style-type: none"> ● Doctor ● Nurse <ul style="list-style-type: none"> ➤ Advanced level nurses (13 years of basic education + 4 years of specialized education + more than 1 year of research) ➤ Intermediate level nurses (including midwives (obstetric nurses): 12–13 years of basic education + 4 years of specialized education) ➤ Basic level nurses (9 years of basic education + at least 1 year of specialized education: to be abolished in the future) ● Technicians (DTT: Diagnostic or Therapeutic Technicians: laboratory technicians, pharmacists) ● Other staffs (hospital support staff: clerks, cleaning staff, etc.)

⁴⁷ Official Gazette of the Angolan Government. Decreto n.º 185/18 August 6, 2018

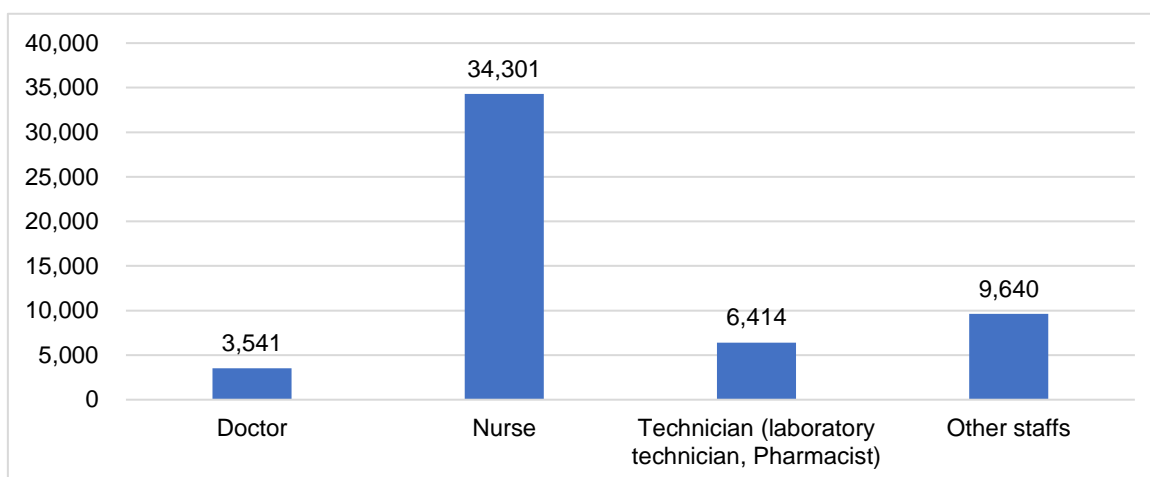


Figure 25: Health Human Resources in Angola (2011)

Source: Ministry of Public Administration, Employment and Social Security/Ministry of Public Administration, Labor and Social Security

3.1.2. Health Human Resources Development Plan

The National Directorate of Human Resources (Direcção Nacional dos Recursos humanos: DNRH) of the MoH had prepared a 10-year human resources development plan for 1997–2007 as a health human resources development policy. This was followed by other national and health policies such as Angola 2025 and the Road Map for Scaling up the Human Resources for Health: for improved health service delivery in the African region 2012–2025, and the National Human Resources Development Plan 2013–2025 (PDRH: Plano Nacional de Desenvolvimento dos Recursos Humanos para a Saúde) was developed.⁴⁸ The National Plan for the Development of Human Resources for Health (PDRH) 2013–2025 aims to achieve the following nine global goals through rapid recruitment of intermediate and advanced level health personnel by 2025:

1. Achievement of the targets defined in the “Roadmap for Scaling Up Human Resources for Health: for improved health service delivery in the African Region 2012–2025”
2. Achievement of targets set in-country (Table 23)
3. Improvement of the training capacity of MOH training institutions
4. Addressing shortages and reducing excess of health human resources
5. Reducing inequalities in health human resources among provinces
6. Reducing inequalities in health human resources among municipalities in the province
7. Improving the performance of health human resources in quantitative and qualitative terms
8. Management of health human resources in the national health system
9. Embedding better definition of functions

⁴⁸ Article 22 of Official Gazette of the Angolan Government n.º34/11

Table 23: Goals set in the National Human Resource Development Plan (PDRH) 2013-2025 (excerpt)

- Update the national health human resource development and management plan
- Train 7,000 nurses and technicians (DTT: Diagnostic or Therapeutic Technicians: laboratory technicians, pharmacists, etc.)
- Improve the quality of educational programs in educational institutions, including basic and intermediate level schools
- Prioritize disease prevention and health promotion, and train community agents to serve as a bridge between health facilities and households.
- Train 20 researchers with doctoral degrees by 2020, 755 with master's degrees (240 doctors, 66 dentists, 400 nurses, 49 pharmacists), 181 with doctoral degrees (50 doctors, 19 dentists, 100 nurses, 14 pharmacists), etc.

3.1.3. Health Human Resources Budget / Finance

The cost of wages and training required for health human resources in 2015–2025, as estimated in 2014 in the National Human Resource Development Plan (PDRH) 2013–2025, was 3,500.5 billion AOA (about \$35 billion; 2014 conversion). Of this total, costs including wages and salaries account for 93% of total expenditures, while training costs are estimated to require 236 billion AOA (about \$2.3 billion) over 11 years. With regard to personnel costs, the basic salaries for each job category of health personnel working in public health facilities are shown in Table 24 for each job level.

Table 24: Base Salary for each Position of Health Human Resources

	Rank	AOA/\$
Doctor	Chief Physician of the Service	405,265.65AOA/632\$
	Graduated Assistant Physician - A	393,346.07AOA/613\$
	Graduated Assistant Physician - B	381,426.49 AOA/595\$
	Graduated Assistant Physician - C	357,587.34 AOA/557\$
	Assistant Physician	333,748.18 AOA/520\$
	Internal Specialist Physician / General Physician	270,177.10 AOA/421\$
Nurse	Nursing Director	295,630.39 AOA/461\$
	Specialist Nurse of 1st Class	381,426.49 AOA/595\$
	Specialist Nurse of 2nd Class	357,587.34 AOA/557\$
	Specialist Nurse of 3rd Class	333,748.18 AOA/520\$
	Nurse of 1st Class	301,962.64 AOA/471\$
	Nurse of 2nd Class	270,177.10 AOA/421\$
	Nurse of 3rd Class	238,391.56 AOA/371\$

Source: Decreto n.º 301/18 November 30, 2018

In Angola, decentralization has been progressing and the budget for the purchase of goods, etc., is paid from the budget allocated to each municipality. However, the budget for health personnel has not been decentralized and their salaries are paid by the provincial government, not by the municipal government. As for the hiring of new recruits, based on the decision of the MoH, the provincial health department conducts an open bidding procedure and the provincial government hires the health personnel.

3.1.4. Health Human Resources Production

Regarding the supply system of health human resources, the training of doctors in particular relies heavily on educational institutions in Brazil, Cuba, and Portugal. Pre-service education for doctors is under the jurisdiction of the Ministry of Higher Education, not the MoH. On the other hand, pre-service, post-graduate level and in-service training for nurses and technicians (advanced and intermediate levels) is handled by the National Human Resources Department of the MoH. Table 25 shows the health human resource development institutions and the number of students in each province. In addition, curriculums vary widely among training institutions, and there is no unified curriculum. There is also no national examination. As a result, the level of health personnel varies greatly depending on the school from which they graduated. Training institutes for nurses (advanced and intermediate levels) have training rooms. During the final year of study at the training institution, an internship period outside of school is set aside for eight hours,

Monday through Friday, to experience the work of all departments at a health facility. In 2020, due to the pandemic of the novel coronavirus, internships at some health facilities were cancelled, and some students were not able to receive sufficient internships and did not graduate.

Table 25: Health Workforce Development Institutions and Number of Students (2014)

Region	Province	Number of institutions	Number of students
North	Cabinda	1	18
	Zaire	0	0
	Uige	2	129
North Central	Luanda	17	1,223
	Cuanza Norte	1	50
	Malanje	2	190
	Bengo	1	48
East	Lunda Norte	1	100
	Moxico	2	188
	Lunda Sul	1	72
South West	Cuanza Sul	2	149
	Benguela	2	284
	Namibe	1	53
South Central	Huambo	3	186
	Bié	2	183
	Huíla	2	215
South	Cuando Cubango	1	52
	Cunene	2	151
Total		43	3,291

Source: MoH in Angola, Avaliação da Formação em Saúde em Angola/Evaluation of Health Training in Angola, 2014

3.1.5. Recruitment and Deployment of Human Resources for Health

After graduation from the training institutions, the health personnel are recruited through open tenders. The open tender for civil servants is regulated in the Official Gazette of the Angolan Government (Decreto n.º 102/11, May 23rd, 2011) and is opened by the MoH. The Provincial Health Department is responsible for the procedure of the open tenders, while the Municipal Health Department is assisting in conducting the examinations. The provincial government is the employer of health care providers, and the municipal government/municipal health department does not have the right to make decisions on recruitment. The National Human Resource Development Plan (PDRH) 2013–2025 states that there is a need to strengthen the capacity of provincial and municipal health departments in recruitment.

Applicants need to apply by submitting documents and diplomas proving their proficiency and education in the category they want to bid for. Therefore, even after graduating from the training institute, if there is no position that suits him or her in the open bidding process, or if he or she is not successful, will not be able to work as a health care provider. The National Directorate of Human Resources, the MoH has created and maintains a database that contains information on

all health care providers. However, due to delays in updating the database, some health care providers were receiving salaries even though they were no longer working at the health facility, so information on all health care providers was updated from 2016 to 2019.⁴⁹ In addition, private health facilities are also hiring new graduates, for example, about 100 nurses from the Luanda Technical Health School⁵⁰ are hired every year to work in health facilities operated by Endiama (a private company involved in the diamond business) in Luanda Municipality.

Regarding the deployment of health human resources, there is an uneven distribution among the provinces. Table 26 shows the allocation of doctors in each province. Luanda province, the capital, has the highest number of doctors at 973. Looking at the ratio of doctors per 10,000 population, the national average is 0.94 doctors per 10,000 population. In Bengo province, the province with the highest ratio of doctors, there are 2.53 doctors per 10,000 population, while in Huíla province, the province with the lowest ratio, there are 0.21 doctors per 10,000 population, a difference of 12 times. The National Human Resource Development Plan (PDRH) 2013–2025 aims to have 3.5 doctors in 2020, 5.0 doctors in 2025 per 10,000 population.

Table 26: Allocation of Doctors in each Province (2011)

Region	Province	Number of physicians	Ratio of physicians per 10,000 population
North	Cabinda	52	0.73
	Zaire	57	1.00
	Uige	101	0.71
North Central	Luanda	973	1.49
	Cuanza Norte	72	1.68
	Malanje	94	0.97
	Bengo	89	2.53
East	Lunda Norte	63	0.73
	Moxico	56	0.77
	Lunda Sul	39	0.76
South West	Cuanza Sul	141	0.75
	Benguela	243	1.19
	Namibe	47	1.00
South Central	Huambo	109	0.57
	Bié	55	0.41
	Huíla	49	0.21
South	Cuando Cubango	15	0.29
	Cunene	59	0.61
Total		2,314	0.94

Source: National Health Development Plan (PNDS) 2012–2025, 2014 Census.

In addition, as noted in Table 2, the average number of nurses and midwives per thousand population is 0.99 (2018) in sub-Saharan Africa, while in Angola it is 0.41 (the same year), indicating a low number of nurses and midwives (obstetric nurses). The National Human

⁴⁹ Interviews with MoH officer

⁵⁰ Interviews with Luanda Technical Health School

Resource Development Plan (PDRH) 2013–2025 aims to have 23.35 nurses per 10,000 population in 2020 and 33.35 nurses per 10,000 population in 2025.

In recent years, the MoH has been accelerating the hiring and deployment of new health personnel. However, in some cases, only new health personnel are working in health facilities without assist from seniors and they are deployed after years from their graduation. The problem is that they are out in the field without receiving sufficient in-service training.

In Luanda province, there is a problem of health personnel leaving public health facilities and moving to private health facilities where salaries are better, but the number is small. In rural provinces, however, the problem of health personnel leaving public health facilities is not as serious, as salaries at private health facilities may be lower than those at public health facilities and employment conditions may not be as stable.

3.1.6. Health Human Resources Retention

Health personnel working are often assigned to health facilities far from their homes. In such cases, they have to pay for their transportation, or having to work overnight but not being provided with a good living environment. At some health facilities, especially those in rural areas, health personnel works in shifts every week to save on transportation costs and face challenges on the accommodation such as inadequate electricity and water infrastructure and lack of food. Although the national policy promotes the recruitment of health personnel living near the health facilities, there are few trained personnel in rural areas, and personnel living in urban areas are often assigned to health facilities in rural areas.

There is a provision in the Official Gazette of the Angolan Government in 2003 for remuneration for health care providers in rural areas (allowance for remote areas),⁵¹ but this has not been paid and has become a problem because health care providers in rural health facilities sometimes want to leave.⁵²

In “The current situation of human resources for health in the province of Cabinda in Angola”, the geographical imbalance between rural and urban areas and the health human resource issues affecting the provision of universal access to health services in Cabinda Province are described. In Cabinda Province, most of the health facilities are located in rural areas, and there is a shortage and uneven distribution of health personnel. Although the University of Cabinda's Faculty of Medicine was established in 2007, and the number of health professionals per 10,000 inhabitants is higher than the Angolan average, health professionals in rural health facilities often work in weekly shifts (for example, if two health care providers are assigned to a facility, one work overnight one week and the other rotate the next week) the number of health

⁵¹ Official Gazette of the Angolan Government n.º 01/03 and 12/03 April 8, 2003

⁵² Interview with Bengo Provincial health Department officer

personnel in health facilities is currently lower than the data on staffing. Many of the health care providers do not live in the area where the health facility they are assigned to is located, but rather in the municipal center area. Doctors in urban areas work an average of 39.7 hours per week, compared to 21.7 hours in rural areas; nurses in urban areas work 39.7 hours, compared to 57.2 hours in rural areas. In rural health facilities, nurses tend to have more roles and work longer hours.⁵³ The working hours for common occupations in Angola are from 8:00 to 15:00. With the exception of health care providers in delivery rooms and other areas, most facilities start seeing patients at 8:00 a.m., and outpatient clinics often close around 12:00 or 13:00.

Health care providers may receive non-monetary incentives based on their work performance. For example, health care providers with good performance are given priority to participate in domestic and international training programs, and participation in training programs, especially outside the country, is a major motivation for health care providers. In addition, there is an evaluation system for civil servants, including MoH employees, in which attendance, skills and abilities are evaluated, and according to the results, promotions and transfers are made.

In addition, no system of continuing education has been established. Large hospitals, such as provincial and municipal hospitals, conduct in-house training, but in many cases the content and frequency are not well arranged. There is no systematic system of continuing education.

3.2. Health Financing

To promote UHC, it is essential that the government budget (including social insurance) contributes to the health system. In 2001, the African Union issued the Abuja Declaration, which aims to increase the share of government health expenditure to at least 15% of government expenditure. In contrast, the Angolan government's budget allocation to the health sector is inadequate, as the same value is only 5.4% (2017).

In order to achieve UHC, government spending must be at the level of “out-of-pocket health expenditure as percentage of current health expenditure: 20% or less”⁵⁴, “government health expenditure as a percentage of GDP: 5% or more”, and “government health expenditure per capita: \$86.3 or more”.⁵⁵ However, these values in Angola are 34.1%, 1.3%, and \$53.0 (all in 2017) (Table 27). Although “out-of-pocket health expenditure as a percentage of current health expenditure” and “government health expenditure per capita” fall short of the targets, they are better than the sub-Saharan African averages of 35.5% and \$30.2 (both in 2017). However, “domestic government health expenditure as a percentage of GDP” is lower than the regional

⁵³ The current situation of human resources for health in the province of Cabinda in Angola: is it a limitation to provide universal access to healthcare?

⁵⁴ Xu, K., Saksena, P., Jowett, M., Indikadahena, C., Kutzin, J., & Evans, D. B. Exploring the thresholds of health expenditure for protection against financial risk, World Health Report; 2010

⁵⁵ McIntyre, D., Meheus, F. Fiscal Space for Domestic Funding of Health and Other Social Services. Chatham House Centre on Global Health Security Working Group Papers; 2017

average of 1.9% (2017).

Table 27: Key Health Financing Indicators

Health Financing Indicators	Angola	Sub-Saharan Africa average	Lower-middle-income countries average	Japan	International Goals
Current Health Expenditure (US million dollar)	3,409 (2017)	-	-	531,481 (2017)	-
Current health expenditure as a percentage of GDP (%)	2.8 (2017)	5.1 (2017)	4.1 (2017)	10.9 (2017)	-
Current health expenditure per capita (US Dollar)	114.5 (2017)	83.8 (2017)	80.5 (2017)	4,169.0 (2017)	-
Domestic government health expenditure as a percentage of current health expenditure (%)	46.3 (2017)	36.1 (2017)	33.7 (2017)	84.1 (2017)	-
Out-of-pocket as a percentage of current health expenditure (%)	34.1 (2017)	35.5 (2017)	55.7 (2017)	12.9 (2017)	Less than 20% ^{*1}
Foreign aid as a percentage of current health expenditure (%)	3.1 (2017)	11.2 (2017)	3.4 (2017)	-	-
Domestic government health expenditure as a percentage of GDP (%)	1.3 (2017)	1.9 (2017)	1.4 (2017)	9.2 (2017)	5% or more ^{*2}
Domestic government health expenditure per capita (US dollar)	53.0 (2017)	30.2 (2017)	27.1 (2017)	3,505.8 (2017)	86.3 or more ^{*2}
Domestic government health expenditure as a percentage of government expenditure (%)	5.4 (2017)	-	5.0 (2017)	23.6 (2017)	15% or more

*1: Xu, K., Saksena, P., Jowett, M., Indikadahena, C., Kutzin, J., & Evans, D. B. Exploring the thresholds of health expenditure for protection against financial risk, World Health Report; 2010

*2: McIntyre, D., Meheus, F. Fiscal Space for Domestic Funding of Health and Other Social Services. Chatham House Centre on Global Health Security Working Group Papers; 2017

Source: Prepared by Survey team by World Health Organization Global Health Expenditure database and Africa Scorecard on Domestic Financing for Health, 2018

The collapse of Lehman Brothers in 2007 and the subsequent global recession also led to a decline in health spending by the Angolan government. Domestic government health expenditure per capita declined to \$60.0 in 2010, recovered briefly over the next three to four years, but reached its lowest value in the recent years with only \$42.0 in 2016, due to the global economic slowdown. Meanwhile, the nation's financial risks have consistently increased, with the “out-of-pocket as a percentage of current health expenditure” rising to \$39.1 in 2017.

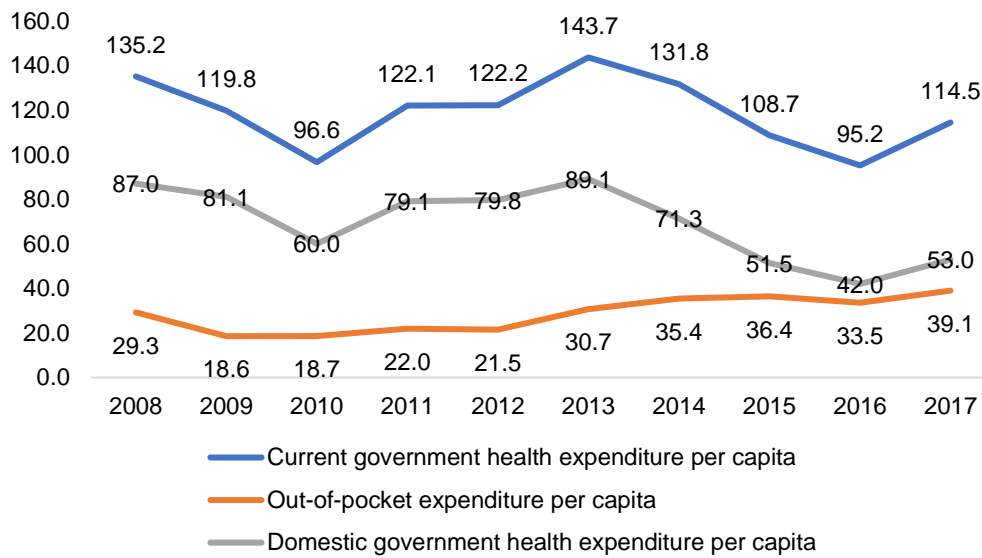


Figure 26: Per capita Health Expenditure in Angola (Unit: US dollar)

Source: World Health Organization Global Health Expenditure database

About half of the sources of health expenditure in Angola come from the government budget. In recent years, the government budget has accounted for about 50% of current government health expenditure. On the other hand, “foreign aid as a percentage of current health expenditure” is 3.1% (2017), which is not highly dependent on foreign aid compared to the average of 11.2% in sub-Saharan Africa (although there are some differences in values due to slightly different classification methods, such as “foreign aid” in Table 27 and “aid agencies” in Figure 27). Consistently in recent years, the amount of “out-of-pocket expenditure” has been increasing, as has its share of health expenditures.

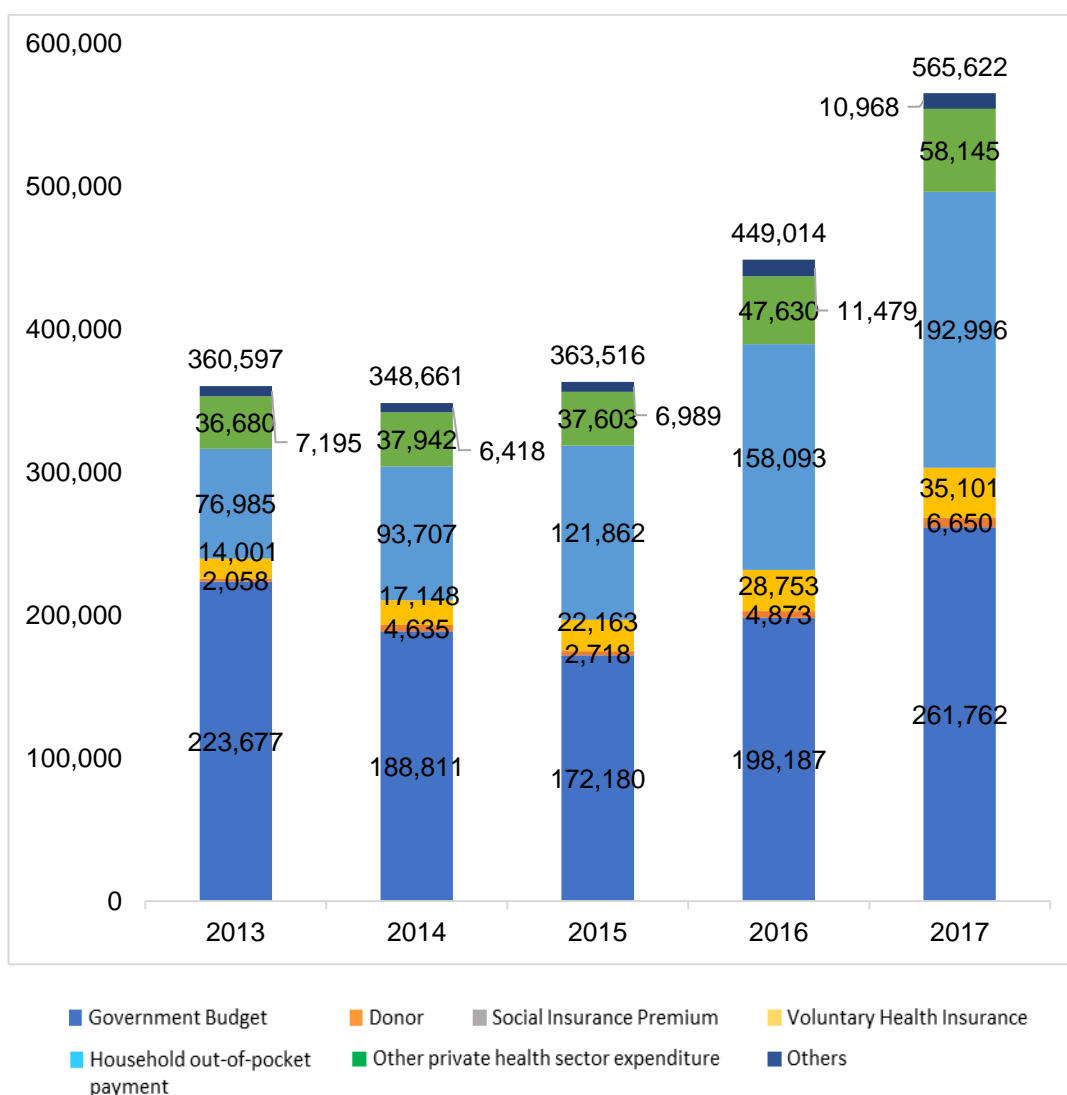


Figure 27: Breakdown of Sources of Current Health Care Expenditure in Angola (Unit: milion AOA)

Source: World Health Organization Global Health Expenditure database

The draft budget of the MoH for 2021 is 220.2 billion Kwanza (AOA) which is approximately 330 million USD. Operating expenses have accounted for the majority of the budget, but capital expenditures have been on the rise in recent years. In the proposed budget for 2021, operation expenses comprise 45.1% of the total budget, capital expenditures are 40.6%, personnel expenses are 14.1%, and capital transfer expenses (0.1%) (Figure 28).

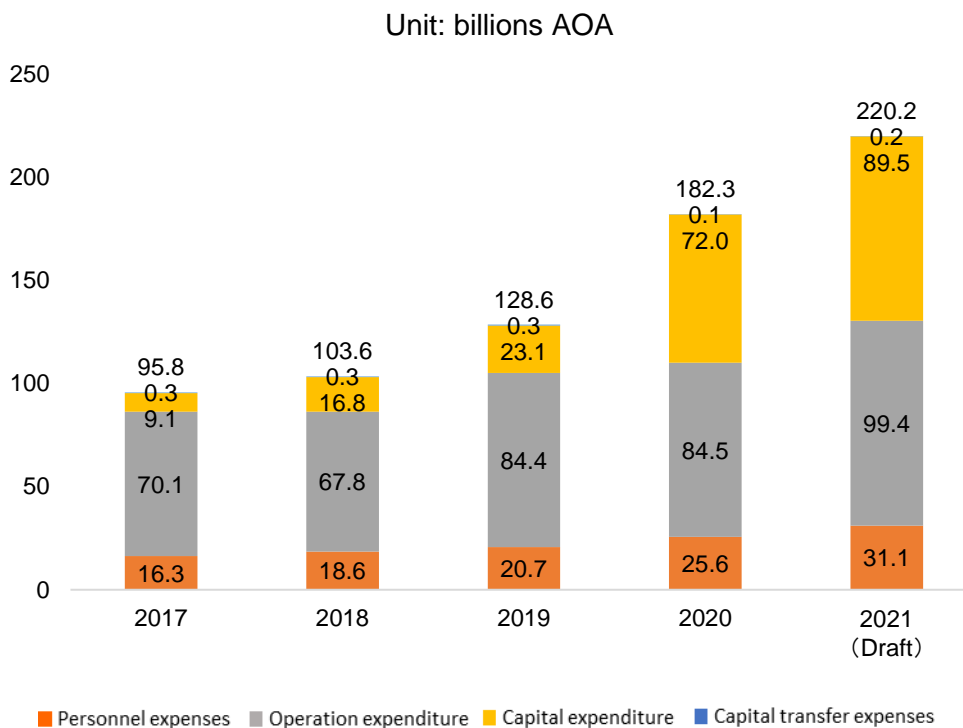


Figure 28 : Breakdown of the Ministry of Health Budget (Unit: billion AOA)

Source: National Budget, Ministry of Finance, Angola

In Angola, patients can use services free of charge, from primary to tertiary care, through the tax system (leveraged system) rather than the social insurance system (Bismarck system).⁵⁶ While the budget for the salaries of the staff working in the health facilities is relatively secure, the budget for consumables such as medicines and utilities such as water and electricity is not sufficiently allocated.⁵⁷ The Angolan government's general government budget is divided into two main categories: the central government budget and the provincial government budget. The MoH compiles the budget of the central government for the tertiary hospitals managed by the ministry, while the budget for the secondary hospitals and primary health care facilities is compiled by the provincial health department under the provincial government, with the municipal government having the authority to execute the budget. As in other sectors, the provincial and municipal governments have autonomy and independence in the management of the health sector. As shown in Figure 29, in the government budget for the health sector in 2020,

⁵⁶ Workers' compensation insurance, which covers benefits for work-related injuries and occupational diseases caused by work, and private health insurance do exist. The extent of the prevalence of workers' compensation insurance is unknown, but voluntary insurance accounted for only 6.2 percent of recurrent health expenditures in 2017, and private health insurance is only available to a limited number of people in Luanda (Health Policy Project. Health Financing Profile: Health Financing Profile: Angola).

⁵⁷ Health Policy Project. Health Financing Profile: Angola. Available from https://www.healthpolicyproject.com/pubs/7887/Angola_HFP.pdf. (Accessed November 29, 2020)

22% (182.3 billion AOA or about \$270 million) of the total budget was allocated to the (central) MoH and 21% (170.6 billion AOA or about \$260 million) to other (central) ministries such as the Office of the President and the Ministry of Home Affairs, while the health sector budget allocated to the state governments was 57% (463.8 billion AOA or about \$700 million). More than half of the health sector budget was allocated to provincial governments, suggesting that decentralization is progressing in terms of budget. However, when preparing and executing the budget, there is a lack of coordination between the finance and health departments at each administrative level, as well as between the administrative levels of the central government, provinces, and municipalities, resulting in duplication of budgets, failure to budget necessary expenses, and lack of compliance with national priorities.⁵⁸ In addition, annual implementation plans are rarely prepared at each administrative level, and as a result, the previous year's budget is simply followed, resulting in inappropriate budgeting.⁵⁹

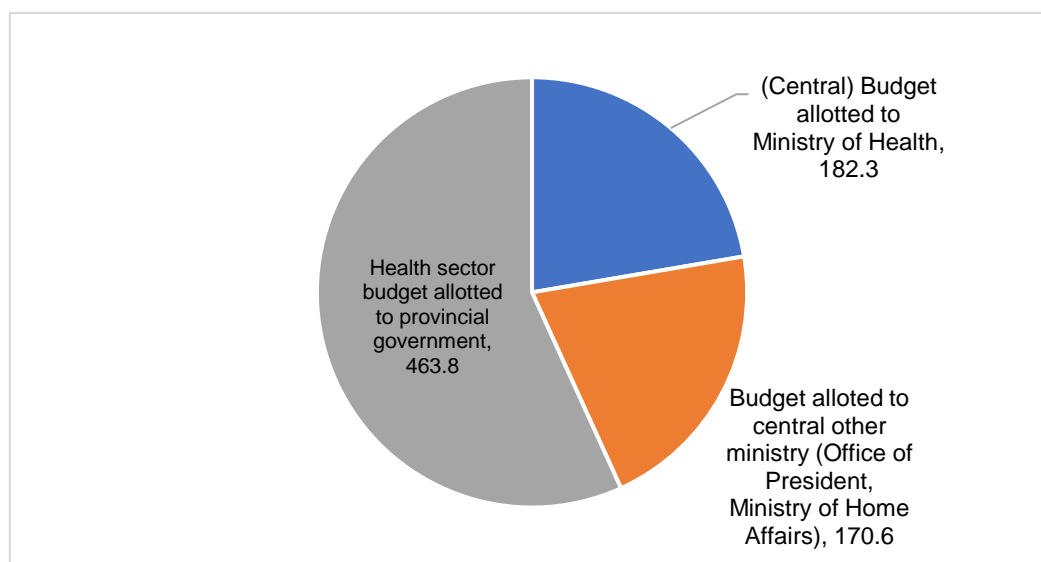


Figure 29: Breakdown of Health Sector Government Budget, 2020
(Unit: billion AOA)

Source: National Budget, Ministry of Finance, Angola

3.3. Health Information System

The Civil Registration and Vital Statistics (CRVS) are information that is fundamental not only to the health sector but also to the administrative system. In Angola, however, only 25% of children under the age of five are registered as births.⁶⁰ Also, due to long-term colonial rule and

⁵⁸ World Bank. Angola Health System Performance Strengthening Project: Project Appraisal Document. 2018

⁵⁹ Programa de Apoio ao Sector da Saúde (PASS) II. Mid-term Evaluation. 2016

⁶⁰ Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015–2016

the civil war that lasted 27 years after independence in 1975, no census was conducted for many years. The 2015-16 Multiple Indicator and Health Survey (IIMS), conducted between October 2015 and March 2016, was the first Demographic and Health Survey (DHS) and the fourth Multiple Indicator Cluster Survey conducted in Angola. The 2015-2016 DHS is a national survey of births, child and maternal health, nutrition, and infectious diseases and provides important information for monitoring and evaluation of health policies and programs. While the DHS is underway for 2020, the most recent data available is the 2015-2016 version.

In addition, the District Health Information Software (DHIS2), a platform for collecting, communicating, analyzing, and reporting health information, is being introduced and disseminated with support from WHO, USAID and UNICEF. When first introduced, it collected information on malaria, HIV, and vaccines, and later data field has been expanded. It now includes data on tuberculosis and community activities such as activities done by ADECOS. As a result of the interviews conducted with PSI, the following problems have arisen: lack of equipment necessary for DHIS2, inadequate internet environment, lack of skills of information inputters on electronic devices, lack of training, and weak involvement of local administration. The Reproductive Health Technical Committee has been working on the formulation of information collection items (variables) for DHIS2. The “Project on Improving Maternal and Child Health Services through the Maternal and Child Health Handbook” proposed that the number of MCH handbooks distributed be added as a variable. The National Development Plan (PDN) 2018–2022 also aims that “at least 95% of the hospitals, municipal health departments, and provincial health departments be included in the DHIS2 digital health information platform and producing monthly reports by 2022”.

In addition, all recording, storage, and reporting of patient information in health facilities is done on a paper basis. The MoH and the provincial and municipal health departments print out the necessary registration books for recording, such as “general examination ledger”, “antenatal care ledger”, “delivery record ledger”, “postnatal checkups ledger”, “pediatric checkups ledger”, “vaccination ledger”, and “HIV/AIDS ledger”. In addition, in the World Bank project, a revised and printed copy of the antenatal care ledgers are have been distributed in the project areas, and health staff was trained.

For the management of health facility information, the Angolan MoH produces a data set called Health Maps (Mapas Sanitários). Health Maps is managed by the Research and Projects Department of the Planning and Statistics Studies Cabinet (Gabinete de Estudos, Planeamento e Estatística: GEPE). The government has stated that “it is necessary to review the Health Maps periodically to ensure a certain equity and distribution of health facilities”.⁶¹ In addition, the Program of Support to the Health Sector II (PASSII), a cooperative project by the EU, prepared

⁶¹ Official Gazette of Angola, Decreto N.º 222, November 24, 2010

Health Maps for the project area. The Health Maps include geographical maps of health facilities as well as information on the number of health staff in each municipality, infrastructure, health services, number of hospital beds, and the number of ambulances and other transportation vehicles owned by the municipality.⁶²

Regarding vital statistics, the “birth registration system” and “death registration system” are described in the next sub-sections.

(1) Birth Registration System

Birth registration is a fundamental child right enshrined in the International Convention on the Rights of the Child and the African Charter (Article 6) to ensure that every child has the right to citizenship through a birth certificate or birth certificates. Birth registration is free of charge and is a legal obligation that must be fulfilled within 30 days of birth.⁶³ Children under the age of five who have not been registered can register their births free of charge. In addition, the following information is required for birth registration (Table 28), which is electronic only in Luanda province, but manually in other provinces. Birth records are obtained after birth registration, and birth records are required for education, vaccines, personal identification and travel.

Table 28: Information Required at Birth Registration

	Information needed
Child	Name, sex, date of birth, date of registration, place of occurrence, place of registration, type of birth (single, twin, triplet and so forth), attendant at birth, type of place of occurrence (hospital, home, etc.)
Mother of the child	Place of usual residence, occupation
Father of the child	Place of usual residence, occupation

Source: UNICEF. CRVS profiles - Angola. Available <https://data.unicef.org/crvs/angola/> (Accessed 2020.12.05)

(2) Death Registration System

Registration of deaths is also handled by the National Registration and Notary Services Department of the Ministry of Justice. Registration of deaths is free of charge and is a legal obligation to be done within 48 hours of death. In addition, the following information is required for death registration (Table 29), which is electronic only in Luanda province, but manually in other provinces.

⁶² Mapa Sanitário de Benguela 2018

⁶³ UNICEF Data: Monitoring the situation of children and women

Table 29: Information Required at Death Registration

	Information needed
Regarding the deceased	Name, sex, date of birth or age, place of usual residence, marital status
Regarding the deaths	Date of death, date of registration, place of occurrence, place of registration, cause of death, cemetery

Source: UNICEF. CRVS profiles - Angola. Available <https://data.unicef.org/crvs/angola/> (Accessed 2020.12.05)

3.4. Procurement and Supply for Facilities, Equipment, and Medical Supplies

(1) Placement and Operation of Health Facilities

Health facilities in Angola are organized in three levels. The primary health care level consists of health posts, health centers, and municipal hospitals. The second health level consists of general hospitals that provide services of intermediate complexity. The tertiary level consists of a central hospital and specialized hospitals such as the Lucrecia Paím Maternity Hospital. In Angola, the referral system is not well established, and at the primary health care level, the health posts and centers are often outdated and inadequately equipped and staffed. In addition, there are cases where people go directly to the secondary and tertiary levels of health care due to “long waiting times” and “poor quality of health services”. Figure 30 shows the health facilities and their management systems, and Table 30 shows the services provided at each health facility level and the target population size. The National Human Resource Development Plan (PDRH) 2013–2025 also sets out the cadres and number of health personnel to be deployed in each health facility. The targets by 2025 are shown in Table 31.

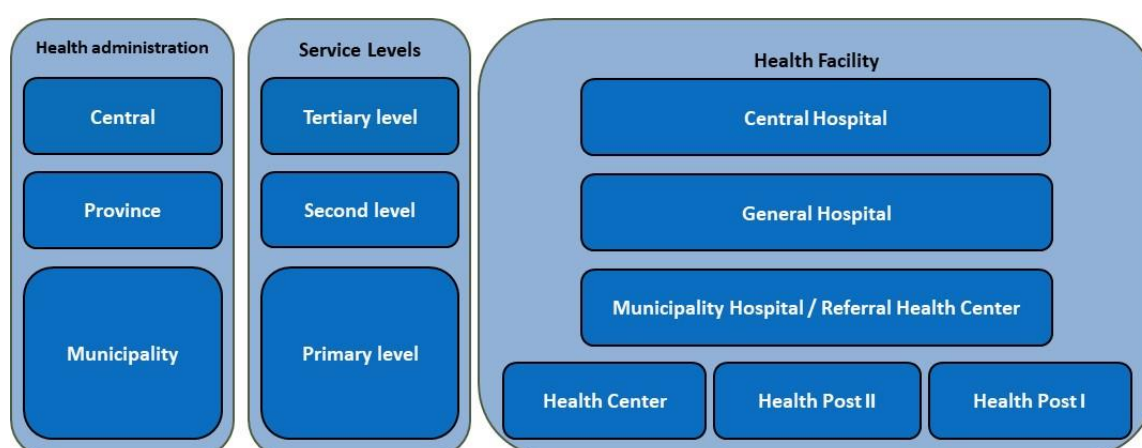


Figure 30: Health facilities and management structure

Source: Prepared by the survey team based on the National Health Development Plan (PNDS) 2012–2025

Table 30: Services Provided in each Health Facility Type and Target Population Size

Health facility	Services provided	Target population size
Health Post I	Primary health care level consultation, immunizations, child growth monitoring, antenatal cares, family planning, etc.	5,000 people
Higher-level Health Posts (Health Post II)	Health Post + Laboratory	20,000-40,000 people
Health Center	Higher Health Post + 24-hour delivery support	75,000 people
Municipal and District Hospitals/Higher Health Centers	Health Center + Internal Medicine, Radiology, Nutrition Guidance and Therapy	150,000 people (rural areas) 500,000 people (urban areas)
General Hospital	Municipal and District Hospital/Higher Health Center + Surgery, Blood Transfusion, Specialty Medicine and Pediatrics, Obstetrics and Gynecology	750,000 people

Source: National Health Development Plan (PNDS) 2012–2025

Table 31: Type and number of health personnel to be developed to each health facility (target for 2025)

Health facility	Type and number of health personnel to be deployed
Health Post	At least 2 intermediate level nurses
	At least one doctor per municipality to support health posts and centers without a doctor
Health Center	2 general doctors, 1 advanced level nurse, 22 intermediate level nurses (maternal health, pediatrics, stomatology, nutrition), 10 basic level nurses, 7 midwives (obstetric nurses), 10 technicians (DTT: laboratory technician, X-ray technician, pharmacy technician)
Maternal and child center	1 specialist doctor per 4 beds and, 1 nurse per 0.5 bed
Municipal hospital	6 doctors (2 general doctors, 1 internal medicine, 1 surgeon, 1 obstetrician gynecologist, 1 pediatrician), 13 advanced level nurses (including 1 anesthetist), 49 intermediate level nurses (including 5 instrumentalists), 30 basic level nurses, 20 technicians (DTT: laboratory technician, X-ray technician, pharmacy technician)
Provincial hospital	1 specialist doctor per 12 to 15 beds, 1 doctor per 8 to 10 beds, 4 nurses per bed, 1 nurse per 0.5 bed in some services (e.g., maternity), 1.1 other staffs per bed
National hospital/ Emergency hospital	At least 1 specialist doctor per 12 to 15 beds, 1 doctor per 8 to 10 beds, 4 nurses per bed, 1 nurse per 0.5 bed in some services (e.g., maternity), 1.1 other staffs per bed

Source: National Human Resource Development Plan (PDRH) 2013–2025

There are 2,356 public health facilities in Angola, of which 1,854 were functioning during 2007-2011. Of the health facilities that were functioning, 51% had no water supply in place. The breakdown of the number of each facility level by province is shown in Table 32. The more rural the area, the higher the number of health posts. This is due to the fact that health posts are located in underpopulated areas and health centers are located in densely populated areas. In addition, the number of health facilities needed by 2025, estimated by the Planning and Statistics Studies Cabinet (GEPE) based on Angola's estimated population for 2025, is 6,606, with a breakdown in Table 33.

Table 32: Number of Public Health Facilities by Province

Province	Health Post	Health Center	Maternal and Child Center	National Hospital / Central Hospital	Municipal Hospital	Provincial Hospital	Others	No information	Total
Bengo	93	17	1		9	1	3		124
Benguela	140	26	1	2	14	1	2	5	191
Bié	63	6	3		10	3		10	95
Cabinda	80	17	2		9	1			109
Cuando Cubango	90	18			6	1			115
Cuanza Norte	82	42	4	2	5	1	1	26	163
Cuanza Sul	172	35	1	1	2	4	2	15	232
Cunene	64	6			10	1			81
Huambo	86	16	1		8	1	3		115
Huíla	184	22	7		14	1	16		244
Luanda	42	19		15	20		2	27	125
Lunda Norte	61	11			7	2	1		82
Lunda Sul	63	13	3		4	1			84
Malanje	108	12	3		15	1	3		142
Moxico	88	6	3		10	1	6		114
Namibe	58	11			6	2			77
Uíge	120	34	10		10	2			176
Zaire	56	20	4		6	1			87
Total	1,650	331	43	20	165	25	39	83	2,356

Source: National Health Development Plan (PNDS) 2012–2025, Health Maps/Mapas Sanitários, Ministry of Health of Angola. 2006 data for Luanda, Benguela, Ouambo, Wirá and Bié provinces; 2009 data for Malanje, Cabinda, North Kwanza, Zaire, Bengo and Kunene provinces. Lundanoorte, Lundas Sur, Moxico, Cuando Cucbango, Kwanza Sur, Namibe, and Uygur are from 2010.

Table 33: Number of health facilities in 2009 and number of health facilities needed by 2025 (GEPE Estimate)

Type of health facility	2009	2025
Health Post	1,393	5,737
Health Center	308	382
Maternal and Child center	37	191
National/Central Hospital	18	29
Provincial Hospital	23	38
Municipal Hospital	152	191
Other	22	38
No information	26	-
Total	1,979	6,606

Source: National Health Development Plan (PNDS) 2012–2025

According to the National Health Development Plan (PNDS) 2012–2025, patients have to travel 48 km to health facilities on national average, and in Lunda Norte, Lunda Sul, Moxico, Cuando Cubango, and Namibe, access is even worse, with patients having to travel an average of over 75 km to health facilities. The province of Cuando Cuebango has the longest distance, requiring an average travel of 122 km. In addition, the roads to the health facilities are often not paved, and some health facilities are not accessible by car, forcing patients to travel on foot or by motorcycle. It is said that there are three reasons why pregnant women lose their lives: (1) delay in decision making, (2) delay in transportation and access to a health facility, and (3) delay in treatment.⁶⁴ In Angola, the problem of delay in transportation and access is serious. The municipal health department dispatches “mobile teams” to rural areas with poor access as part of its community outreach program. The frequency of dispatch and status of activities vary from municipality to municipality, but they provide antenatal care, vaccines, and other services. However, there are some financial problems such as transportation costs.⁶⁵ In Angola, there are community health workers called Community and Health Development Agents (Agente de Desenvolvimento Comunitário e Sanitário: ADECOS) in all 18 provinces. The governing body is the Social Support Fund (Fundo de Apoio Social: FAS) of the Ministry of Territorial Administration and State Reform (Ministério da Administração do Território e Reforma do Estado). ADECOS receives five weeks or 200 hours of training on water and sanitation, malaria, maternal and child health, family planning, HIV/AIDS, etc., and plays a complementary role to

⁶⁴ Thaddeus, S. and Maine, D. (1994) Too far to walk: Maternal mortality in context. *Social Science & Medicine*, 38, 1091-1110. doi:10.1016/0277-9536(94)90226-7

⁶⁵ Interviews with Bengo Provincial Department officer

health personnel by conducting awareness-raising activities, especially in rural areas.⁶⁶ In addition, when ADECOS conducts its activities, it requests the cooperation of local authorities (SOBAs) and conducts community-wide activities, for example, involving men in family planning activities. However, there have been some administrative confusion (change of jurisdiction of the governing body, from the Social Support Fund (FAS) to the municipalities and there are problems of non-payment of salaries).

In addition, Angola's private health facilities provide care not only in large urban areas but also in areas where public health care networks and access are limited or non-existent. Some of the private health facilities charge high fees for their services, as the quality of care does not match the price. Private, not-for-profit health facilities, composed of churches, religious organizations, and non-governmental organizations (NGOs), provide health care to the poor in peri-urban and rural areas. In Angola, there are about a total of 3,287 private health facilities, most of which are pharmacies (1,574), nurse health posts (627), and medical centers with doctors (505), and 60 % of these are in Luanda province.⁶⁷

(2) Supply Chain of Medical Equipment and Pharmaceuticals

The Central Purchasing of Medicines and Medical Resources in Angola (Central de Compras de Medicamentos e Meios Medicos de Angola: CECOMA), established in 2013, is responsible for most of the public procurement of medicines in Angola. In the Official Gazette, it is clearly stated that its role is “to be a public institution that procures, distributes, and maintains medical equipment and materials in collaboration with other agencies of the Ministry of Health”.⁶⁸ As a result, the procurement, storage, and transportation of various goods by the MoH are centralized in CECOMA. A warehouse has been established in Luanda province as central warehouses and 3 warehouses in Huíla, Malanje and Benguela provinces as regional warehouses, with the aim of building a total of 18 regional warehouses. USAID is providing technical assistance to implement a project to strengthen the public health pharmaceuticals system, including the preparation of a list of essential medicines, develop and manage the supply chain, training of human resources to manage the supply chain, and strengthening of the information system for medicines and other consumables.

In Angola, the flow from the central warehouse to the provincial warehouses uses the “pull method” for delivery of medicines and other consumables, which is based on the number of requests, while the flow from the provincial warehouses to the municipal warehouses and health facilities uses the “push method”. However, due to the lack of a distribution plan in place, some

⁶⁶ ADECOS training material (COLETÁNEA DE TEXTOS PARA A FORMAÇÃO DOS AGENTES DE DESENVOLVIMENTO COMUNITÁRIO E SANITÁRIO ADECOS 2014)

⁶⁷ National Health Development Plan (PNDS) 2012–2025, p.42

⁶⁸ Angolan Government Official Gazette Decreto n.º 13/ 30 January 2018

municipalities use a “pull method” to deliver based on requests from health facilities. In addition, standard procedures for procurement and logistics management have not been sufficiently developed.⁶⁹ As a result, health facilities often run out of stock of essential medicines, and patients/users are forced to purchase medicines from private pharmacies at their own expense, which are supposed to be provided free of charge by the health facilities.

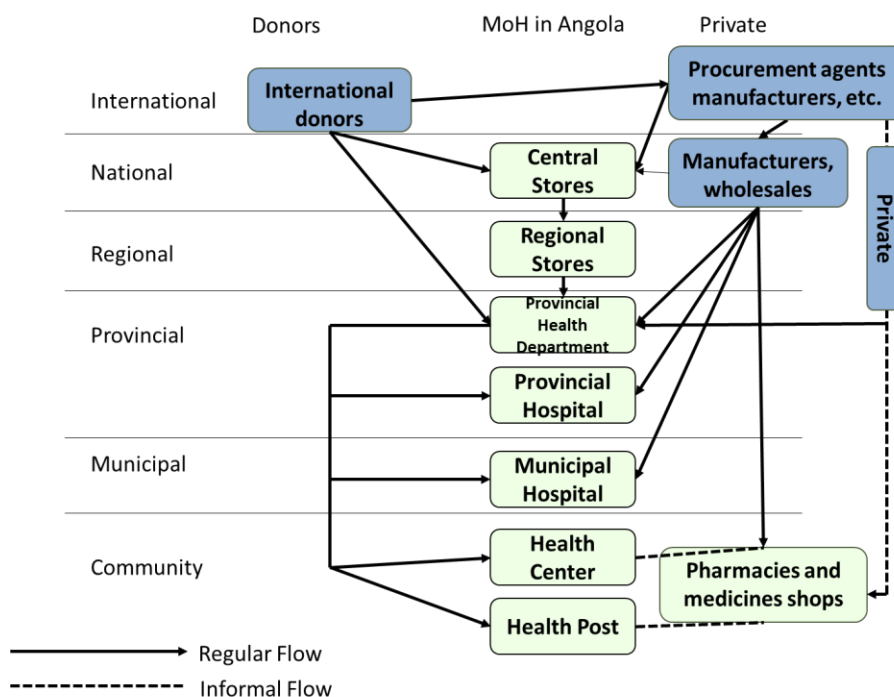


Figure 31: Distribution Flow of Medicines, etc.

Source: USAID Angola Health System Assessment 2010.

3.5. Management and Supervisory Functions

The Ministry of Health is responsible for policies, plans and regulations, public health programs, and procurement and distribution of essential medicines. It has jurisdiction over central and specialized hospitals, but health facilities under provincial levels are under the jurisdiction of the provincial health department or municipal health department. The organizational structure of the MoH, the administration responsible for health policy, is shown in Figure 32. In October 2020, the National Directorate of Public Health was reorganized into a new Department of Primary Health Care, instead of the previous Department of Reproductive Health. The Primary Health Care Department includes the units of nutrition, child health, reproductive health, adolescent and young adult health, oral health, and health promotion.

⁶⁹ Systems for Improved Access to Pharmaceuticals and Services (SIAPS) Program. Analysis of the Angolan Public Health Supply Chain System: Report. 2013

There is Ethics and Humanization Cabinet, whose primary task is to promote the provision of ethical and humane care, and whose competencies are listed in Table 34.

Table 34: Key competencies of the Ethics and Humanization Cabinet

- Create an ethical and humanistic culture for patients based on team spirit and collaboration among all health care providers for the purpose of continuous improvement in quality, ethics, and care
- Create and implement new humanization initiatives for health facilities that are effective for both patients and health care providers
- Facilitate research to assess patient and health care provider satisfaction
- Strengthen and collaborate with all humanization initiatives that exist in the public health care network
- Establish partnerships between public and private institutions and facilitate the exchange of knowledge and experience in the field of ethics and humanization
- Facilitate the establishment of user offices to support the organization and its functions.

Source: Angolan Government Official Gazette Decreto n. °13/ 30 January 2018

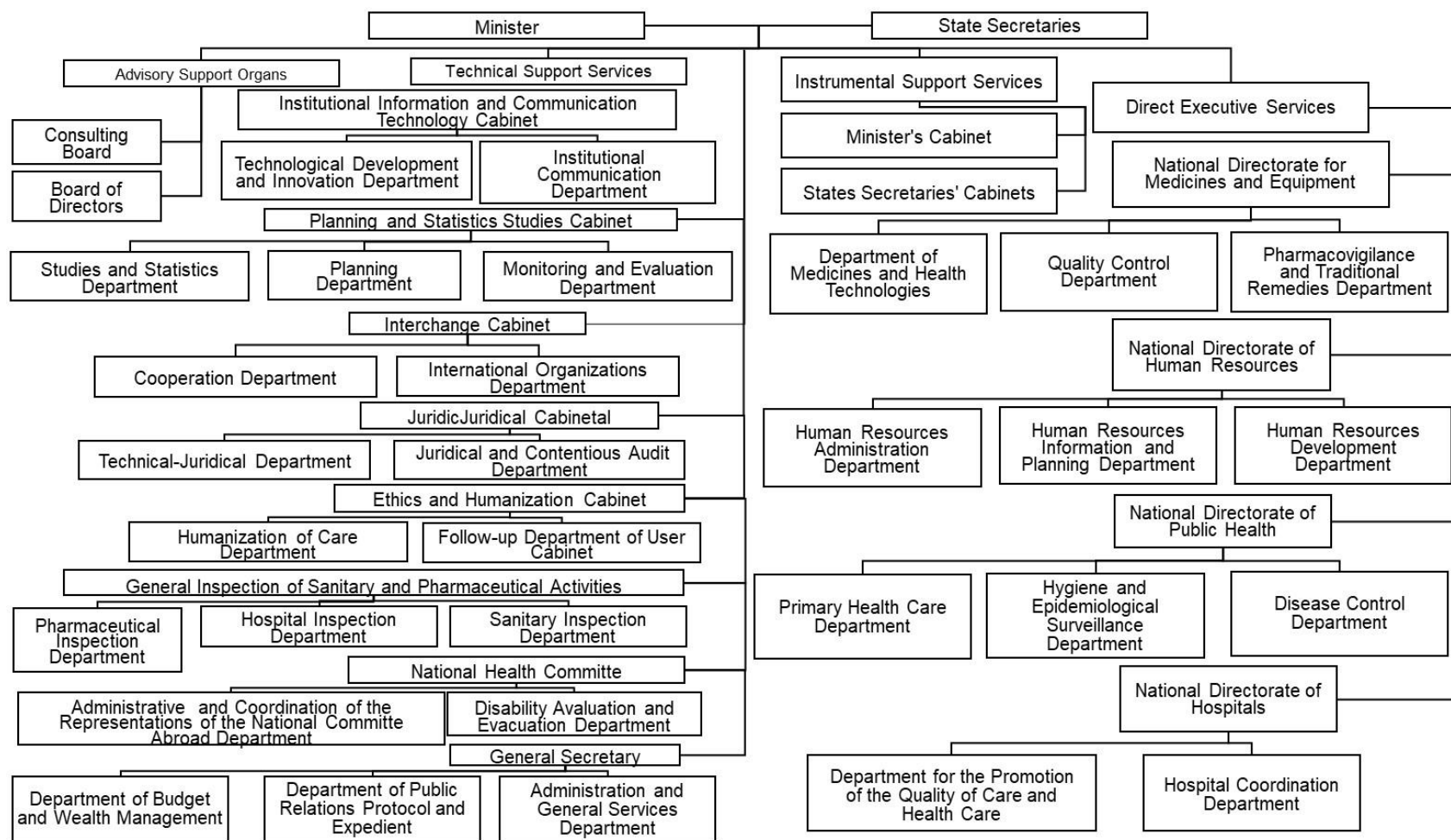


Figure 32: Organization of the Angolan Ministry of Health⁷⁰

⁷⁰ Source: Official Gazette of the Angolan Government, Decreto n. °170/ October 26, 2020.

4. Identification of cooperation needs and recommendations for policy

4.1. Health sector challenges and cooperation needs

The challenges and needs identified in the analysis of the current state of the health sector in Angola can be summarized as shown in Table 35.

Table 3536: Challenges and Needs of the Health Sector in Angola

Current status of disease burden	High burden for maternal and child health and infectious diseases		
Challenges	<ul style="list-style-type: none"> The use of primary health care is hindered Suboptimal use of various health services, especially in rural areas 		
	User fees are charged for service use	Health facilities are far away	The quality of services provided is low
Possible causes	<ul style="list-style-type: none"> Stock-outs of medicines and other supplies at health facilities 	<ul style="list-style-type: none"> No progress in improving health facilities and equipment In some cases, even when facilities are constructed, personnel are not deployed 	<ul style="list-style-type: none"> Inadequate skills and poor attitude of health personnel Stock-outs of medicines, unavailability of human resources
Necessary measures	<ul style="list-style-type: none"> Strengthening the logistics management capacity of the Provincial and the Municipal health departments 	<ul style="list-style-type: none"> Strengthening the recruitment and employment capacity of the Provincial and the Municipal health departments 	<ul style="list-style-type: none"> Establishing a patient/user-centered service delivery system

(1) Current status of disease burden

High burden for maternal and child health and infectious diseases

In terms of major causes of death at all ages, deaths from infectious diseases account for the largest share of all deaths at 42% (2019), although the burden of non-communicable diseases is increasing. Among infectious diseases, respiratory infections including childhood pneumonia (13%) and HIV/AIDS and sexually transmitted diseases (10%), enteric infections represented by diarrhea (7%), and malaria and neglected tropical diseases (NTDs: 8%) account for a particularly large share of death causes. Among children aged 1 month to under 5 years, pneumonia, diarrhea, malaria, and vaccine-preventable diseases accounted for 56% (2015) of death causes. Many of these deaths are preventable and treatable in primary health care. Perinatal and neonatal disorders are also the third leading cause of death at 11% (2019) of all deaths. A large proportion of maternal deaths are caused by direct obstetric deaths such as gestational hypertension (16.9% of maternal deaths in 2014), hemorrhage before and after delivery (postpartum hemorrhage: 15.6%, abnormal

hemorrhage before delivery: 8.7%), and sepsis (10.6%), which can be avoided by emergency obstetric care, antenatal care, delivery in the presence of a skilled provider, and postnatal care. Although Angola's maternal mortality rate (per 100,000 live births) has decreased significantly, from 827 in 2000 to 241 in 2017, there is still much room for improvement.

(2) Challenges

Primary health care is underutilized, especially in rural areas.

In 2015, Angola's UHC service coverage indicator was 40, which is poor compared to the regional average and the average of countries with comparable incomes. The UHC Service Coverage Index shows that service utilization in "maternal and child health" and "infectious diseases" is hindered, and it is important to promote service utilization in these areas to achieve UHC.

In addition, there are regional disparities in the use of various services. For example, the percentage of pregnant women who received four or more antenatal care and the percentage of deliveries in health facilities are 73.8% (2015-2016) and 64.5%, respectively, in urban areas, while in rural areas the percentages are 39.4% and 16.8%. Similarly, when an under-five child was suspected of having an acute respiratory infection, 59.8% of urban residents used health services, while only 32.4% of rural residents did so.

Medical user fees are charged when using health services that are supposed to be free of charge.

In Angola, people are supposed to be able to use health services free of charge, from primary to tertiary health care. However, in reality, the user fee is charged when using health services, which is a barrier to the use of these services. When women were asked about the challenges they face when using maternal and child health services, the highest number of women (63.0%, 2015–16) cited "having the money for medical treatment". The percentage of the population with health-related expenditures of 10% and 25% or more of household expenditure/income, which is also a UHC monitoring indicator to measure progress in achieving "protection from financial risk" was 12.4% and 4.5% (2008), respectively, worse than the sub-Saharan African average (10.3% and 2.5%; 2010). Furthermore, financial risks may have increased in recent years since the data was collected in 2008, with the "out-of-pocket expenditure per capita" rising from \$29.3 in 2008 to \$39.1 in 2017.

Poor physical access to health facilities exists as facilities are far away.

The distance to the health facility was also the second most common challenge in using the maternal and child health services mentioned earlier at 51.8%. According to the National Health Development Plan (PNDS) 2012–2025, residents have to travel an average of 48 km on national

average to access health facilities, and an average of 122 km in the province of Cuando Cubango, the harshest environment, indicating that the distance to the health facility is also a significant challenge in using the health service. In addition, the roads to the health facilities are often not paved, and some health facilities are inaccessible by car, forcing people to travel on foot or by motorcycle. In Angola, the problem of delayed transport and access is serious, and it is one of the three root causes for pregnant and nursing mothers to lose their lives: (1) delay in decision making, (2) delay in transportation and access, and (3) delay in treatment.

Low quality of services provided.

In addition to the previous survey that asked about barriers in using maternal and child health services, the survey that examined the reasons for not giving birth at a health facility also found that “the facility is too far away” was the most common answer at 22.5% (2010). In addition, “home is more comfortable” was the second most common answer at 16.3%. The survey also asked about perceptions of the quality of health services, with the total of “very low” and “low” averaging 33.0% (0.7% for “very high” and 12.3% for “high”, for a total of 13.0%) for the entire survey area. In rural areas, the total of “very low” and “low” was 49.0% (“very high” 0.0%, “high” 7.3%, total 7.3%). This suggests that the use of services is not widespread due to the discomfort of giving birth in a health facility or the perceived low quality of the services provided. In addition, interviews with experts of the “Project for Improving Maternal and Child Health Services through the implementation of the Maternal and Child Health Handbook” indicated that the attitude of health care providers toward users may be discouraging them from using health services.

(3) Possible causes and necessary measures

Challenge 1: User fees are charged when using health services that are supposed to be free.

Due to stock-outs of medicines and other supplies at health facilities, users have to purchase them at their own expense.

Many public health facilities are running out of stock of medicines and other supplies, so users are forced to purchase them at their own expense from pharmacies and other private health facilities. Examples of out-of-stock medicines include iron pills provided to pregnant women during antenatal care, condoms and other contraceptives, vaccines for child immunizations, HIV tests, and other items that are essential for the provision of basic services are often unavailable. Not only are patients and users forced to bear the cost of their health care, but even if they can pay for health services, they may not be able to receive (adequate) services due to the unavailability of these medicines.

In Angola, medicines and other supplies are procured by the Central Purchase of Medicines and Medical Resources of Angola, which is responsible for delivering to the Provincial Health

Department. The Provincial and Municipal Health Departments are responsible for the “last mile” distribution to the health facilities. However, it has been pointed out that the Provincial and the Municipal Health Departments have not formulated appropriate distribution plans and have not sufficiently developed standard procedures for logistics management.

Challenge 2: Poor physical access to health facilities exists as the facilities are far away.

There are cases where health facilities have been established, but health personnel and equipment are not in place.

As stated earlier that people are required to travel long distances to health facilities, a situation has also arisen where “facilities exist, but are not operating/functioning”. In some cases, even if a facility is built, the lack of sufficient health personnel limits the type and amount of services provided, or the operation of the facility is suspended.

Especially in rural areas, there are not enough health personnel. For example, in Bengo, the province with the largest number of physicians, there are 2.53 physicians (per 10,000 population), while in Huila, the province with the smallest number of physicians, there are only 0.21, a difference of 12 times. Although there is a provision for special remuneration for health personnel working in rural areas, the actual payment is not made, and there is also a problem of inadequate living environment for those who are required to work overnight. In other countries, in rural areas where there are not enough health personnel, community resources are used to deliver health services. In Angola, ADECOS, Community and Health Development Agents, is being developed, but its role is to complement that of the health personnel, and its main task is to raise awareness, not to provide health services such as treatment and diagnosis.

Health personnel are recruited through open tenders. The Provincial Health Department is responsible for the open tender process and the Municipal Health Department assists in conducting the examinations. The Municipal Health Department does not have any decision-making power on recruitment and the Provincial Health Department is the employer of the health workers. The National Human Resource Development Plan (PDRH) 2013-2025 states that there is a need to strengthen the capacity of the Provincial and Municipal Health Departments in recruitment.

Challenge 3: Low quality of services provided

Inadequate skills and poor attitude of health personnel

As mentioned earlier, stock-outs of medicines and other products not only force patients and users to pay out-of-pocket but also create a situation where (adequate) services cannot be provided due to the unavailability of medicines, even if users can pay for medical services. The quality of health care workers is also an issue. There is no uniform curriculum or national examinations for

the training of health personnel in Angola, and the level of health personnel varies greatly depending on the school from which they graduated. There is no systematic continuing education. In addition, there are many reports of patients and users hesitating to use services due to inappropriate attitudes and behaviors of health personnel. For example, a newborn baby born at home was brought to a health facility to be vaccinated by the mother’s sister (not the newborn’s mother), but the health care worker reprimanded her for giving birth at home and sent her home without being vaccinated.

4.2. Recommendations for future cooperation policy

In response to the challenges and causes in the health sector, we propose two possible ways to support the health sector through technical cooperation projects: (1) strengthening the capacity of Provincial and Municipal Health Departments in managing the logistics of medicines and other products, and in recruiting and empowering health personnel, and (2) building a patient- and user-centered service delivery system. Figure 33 shows the challenges, possible causes, and proposed recommendations.

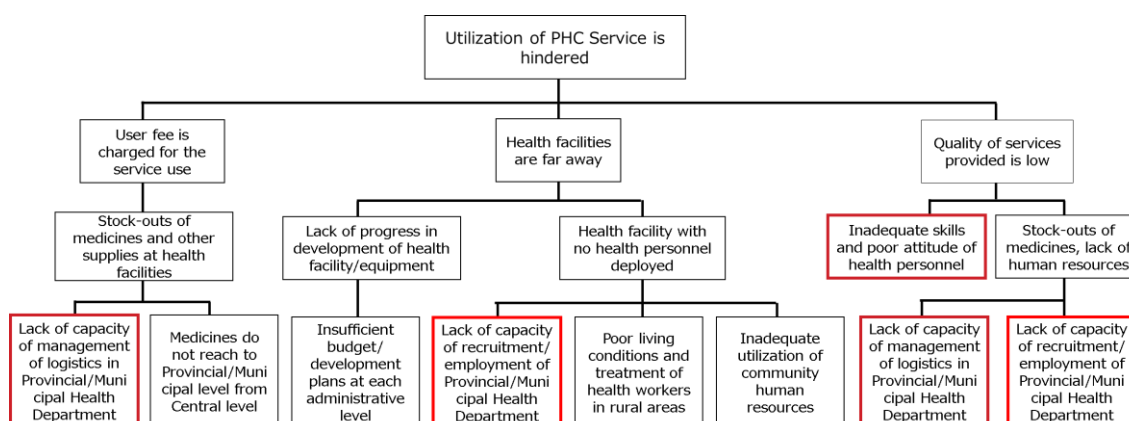


Figure 33: Challenges and Needs of the Health Sector in Angola

In both recommendations, it is desirable to take the approach of developing and implementing a pilot model in a specific region and then expanding the pilot model to a national model based on the lessons learned from the pilot. For this reason, it is necessary to select target areas that have counterparts (CPs) who have the capacity to build and implement the model, and areas that have a certain level of the environment such as basic infrastructure, rather than selecting areas with high mortality rates or particularly limited health staffing. The three provinces of Luanda, Benguela, and Huambo, which are pilot model provinces for the current “Project for Improving Maternal and Child Health Services through the implementation of the Maternal and Child Health Handbook”, can be mentioned as specific candidates. These three provinces have been cooperated with by JICA, have a large target population, and have both urban and rural areas,

so they are suitable as pilot provinces to operate the pilot model for nationwide deployment. In addition, as will be discussed in more detail later, although many development partners are providing support in Luanda, the capital city, due to the presence of the central government and a large population, there is little overlap with other development partners in Benguela and Huambo.

(1) Strengthen the capacity of Provincial and Municipal Health Department in managing the logistics of medicines and other supplies, and in recruiting and capacity building of health personnel.

- Background:

Considering the cooperation scheme of the technical cooperation project, technical transfer to the Ministry of Health and Provincial/Municipal Health Department is expected. In terms of procurement and logistics management of medicines, USAID mainly provides support to the central level, the Central Purchase of Medicines and Medical Resources of Angola, and it is considered desirable that Japan's support should be targeted to the provincial and municipal levels to avoid duplication. In addition, the lack of progress in the development of health facilities and equipment (construction and renovation of facilities and purchase and installation of equipment) is another reason for the long physical distance to health facilities, but it is difficult to provide direct support under the scheme of technical cooperation projects. Similarly, it is difficult for the Ministry of Health and the Provincial/Municipal Health Department to deal with the living environment of health personnel working in rural areas, including their special allowances and other benefits, which are the responsibility of other ministries or agencies. In addition, the Angolan government has a negative attitude toward the use of community personnel to provide health services such as treatment and diagnosis as a substitute for health personnel, making it difficult to promote ADECOS and other initiatives to improve the health service delivery system.

On the other hand, in recent years, the Ministry of Health has increased budgetary measures for the recruitment of health personnel. Moreover, major programs such as HIV/AIDS and malaria are supported by development partners, so it is believed that a certain amount of medicines and other supplies are reaching the provincial health departments. As mentioned above, the Provincial/Municipal Health Department plays a major role in recruiting and deploying health personnel and managing the logistics of medicines and other supplies. However, policy documents and interviews with stakeholders point out the lack of capacity of the Provincial Health Department. In addition, not limited to specific areas such as human resources for health and medicines, annual implementation plans are rarely prepared at each administrative level, and standard

procedures for logistics management are not yet in place, so there is a large room for involvement in the technical cooperation project.

- CP: Human Resources Unit and Pharmaceutical and Equipment Unit, Provincial Health Department
- Overall Goal: The availability of health personnel and medicines will be improved, and the use of primary health care will be promoted.
- Objective: To strengthen the capacity of Provincial/Municipal Health Department through the introduction and establishment of the PDCA (Plan, Do, Check, and Act) cycle for the recruitment and deployment of health personnel and for the logistics management of medicines and other supplies (including budget planning for each).
- Activities:
 - Establishment of guidelines for the formulation of annual implementation plans (including budget plans) using the PDCA cycle, and guidance in accordance with the manual
 - Establishment of standard procedures for hiring health personnel and managing the logistics of pharmaceuticals and other supplies, and guidance in accordance with these procedures
- Note: In the scope of the information collected this time, many development partners are conducting in-service training for each program such as HIV/AIDS control and family planning, but none of them are making cross-sectional efforts such as introduction and establishment of PDCA cycle for recruitment and deployment of health personnel. In terms of logistics management of medicines, as mentioned earlier, USAID is conducting the support mainly to the central level. Although the involvement of the Provincial/Municipal Health Department is limited, as shown in Figure 34, support is also provided in six provinces, namely Zaire, Uije, Cuanza Norte, Malanje, Lunda Norte, and Lunda Sul, and it is necessary to avoid duplication of support areas and activities by USAID. In addition, it is desirable that the same system/rules be used throughout the country, as different logistics management methods in different regions may cause confusion. Therefore, it is necessary not only to avoid duplication of activity areas and their contents with development partners such as USAID, but also to actively cooperate with them in order to create a standardized nationwide system. It should also be noted that the budget for the recruitment of health personnel, in particular, is something that requires negotiation with the provincial financial authorities and the (central) Ministry of Health and Ministry of Finance, and cannot be set by the Provincial Health Department alone, which is expected to act as the CP.

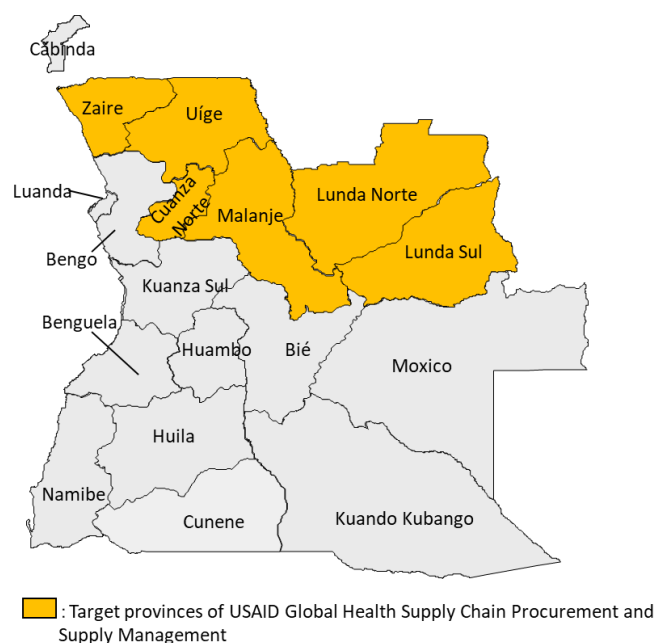


Figure 34: States covered by USAID's procurement and logistics management support for pharmaceuticals and other products

Source: Prepared by the survey team based on USAID Global Health Supply Chain Procurement and Supply Management Program

(2) Establishing a patient/user-centered service delivery system

- Background:

In order to address the challenge of low quality of services provided, the above (1) “Strengthening the capacity of Provincial/Municipal Health Department to manage the logistics of medicines and other supplies and to recruit and empower health personnel” aims to improve the quality of services by deploying health personnel and improving the availability of medicines and other supplies. In addition, there are causes such as inadequate skills and inappropriate attitudes and behaviors of the current health personnel. One of the approaches that Japan has abundant experience in supporting in other countries is “humanization of childbirth”, and Japan has already supported the National Directorate of Public Health of the Ministry of Health of Angola and the Provincial Health Department of Luanda in holding workshops to introduce humanization of childbirth. In Angola, the Ethics and Humanization Cabinet was established within the Ministry of Health to provide patient- and user-centered services, not limited to maternal and child health.

- CP: Ethics and Humanization Cabinet and National Directorate of Public Health, Ministry of Health, and Primary Health Care Department in Provincial Health Department
- Overall Goal: The quality of primary health care services will be improved and service utilization will be promoted.

- Objective: To improve the quality of primary health care services by enhancing the capacity of health personnel through the introduction and establishment of “patient/user-centered services” including “humanization of childbirth”.
- Activities :
 - Conduct in-service training related to the introduction and establishment of patient/user-centered services
 - Development of supervision implementation manuals and systems, and guidance and implementation in accordance with these manuals, etc
- Note: It would also be beneficial to utilize resources from Brazil, which has a high level of expertise and uses the same language, such as the Sofia Feldman Maternity Hospital⁷¹, which has experiences of accepting third-country trainees in “humanization of childbirth”. As far as the information collected this time, no development partner has been providing support in areas related to “patient/user-centered services” other than Brazil’s triangular cooperation with Japan in conducting and cooperating with the above-mentioned third-country training.

4.3. Items to be confirmed in the future

Check the latest status of health service utilization and financial risks.

This report uses information from the Inquérito de Indicadores Múltiplos e de Saúde (IIMS) 2015-2016, the Angolan version of the Demographic and Health Survey (DHS), especially for the utilization of health services. Data collection for the latest IIMS was completed in 2020, and the report is expected to be published soon. Although “having the money to pay for medical services” was cited as a barrier when using health services, the data on “health-related spending as a percentage of household expenditure/income”, which demonstrates the financial risk, was also outdated in 2008 in Angola. In the future, it is necessary to check the latest status of utilization of these health services and financial risks

Quantitative information on the availability of medicines and other products in health facilities.

It was a view shared by the Angolan stakeholders that stock-outs of medicines and other supplies are serious and it have a significant impact on the type and quality of services that can be provided. However, while other countries in Sub-Saharan Africa have quantitative information on the availability of medicines in health facilities through the WHO-supported Service Availability and Review (SARA) and their own health facility surveys, Angola did not have similar information during the scope of the information collection. It is desirable to obtain more

⁷¹ Japan International Cooperation Agency. Second International Training Course on Humanistic Childbirth and Birth Care Conducted at Sofia Feldman Hospital. <https://www.jica.go.jp/brazil/office/information/event/111005.html> (accessed April 8, 2021)

detailed information on the availability of medicines to plan for the strengthening of health administration. It would also be a good idea to conduct the mentioned survey at the start of the support to understand the current situation.

Capacity assessment of possible counterparts

In this survey, we mainly collected information on the current status of the health system and the roles and responsibilities of each level of health administration. A detailed capacity assessment (including staff allocation) of the Provincial and Municipal Health Department is needed in the future to consider the details of the cooperation project.

Appendix

SDGs Global Indicators: Mozambique, Angola, Nigeria

グローバル指標名 Global Indicator Name	モザンビーク/ Mozambique			アンゴラ/ Angola			ナイジェリア/ Nigeria		
	Value	Year	Rating	Value	Year	Rating	Value	Year	Rating
ゴール1 : あらゆる場所のあらゆる形態の貧困を終わらせる Goal 1: End Poverty in all its forms everywhere									
国際的な貧困ラインを下回って生活している人口の割合 Poverty headcount ratio at \$1.90/day (%)	55.5	2020	Red	21.0	2020	Red	47.6	2020	Red
国際的な貧困ラインを下回って生活している人口の割合 Population living below the national poverty line(%)	46.1	2014	Yellow	36.6	2008	Yellow	46	2009	Yellow
ゴール2 : 飢餓を終わらせ、食料安全保障及び栄養改善を実現し、持続可能な農業を促進する End hunger, achieve food security and improved nutrition and promote sustainable agriculture									
栄養不足蔓延率 Prevalence of undernourishment (%)	27.9	2017	Red	25.0	2017	Red	13.4	2017	Yellow
5歳未満の子供の発育阻害の蔓延率 (WHO子ども成長基準で、年齢に対する身長が中央値から標準偏差-2未満) Prevalence of stunting in children under 5 years of age (%)	43.1	2011	Red	37.6	2016	Red	43.6	2016	Red
5歳未満の子供の栄養不良の蔓延率 (WHOの子ども成長基準で、身長に対する体重が、中央値から標準偏差+2超又は-2未満) (タイプ別 (やせ及び肥満)) Prevalence of wasting in children under 5 years of age (%)	6.1	2011	Yellow	4.9	2016	Green	10.8	2016	Yellow
肥満の蔓延率 (成人) Prevalence of obesity, BMI ≥ 30 (% of adult population)	7.2	2016	Green	8.2	2016	Green	8.9	2016	Green
ゴール3 : あらゆる年齢のすべての人々の健康的な生活を確保し、福祉を促進する Goal 3 Ensure healthy lives and promote well-being for all at all ages									
妊産婦死亡率 Maternal mortality rate (per 100,000 live births)	289	2017	Red	241.0	2017	Red	917	2017	Red
専門技能者の立ち会いの下での出産の割合 Proportion of births attended by skilled health personnel	54.3	2011	Red	49.6	2016	Red	40.3	2017	Red
新生児死亡率 Neonatal mortality rate (per 1,000 live births)	27.8	2018	Red	28.5	2018	Red	36.0	2018	Red
5歳未満児死亡率 Mortality rate, under-5 (per 1,000 live births)	73.2	2018	Red	77.2	2018	Red	119.9	2018	Red
非感染者1,000人当たりの新規HIV感染者数 (性別、年齢及び主要層別) Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	5.3	2018	Red	1.0	2018	Yellow	0.7	2018	Yellow
抗レトロウイルス薬を利用しているHIVを保有する成人の割合 (%) People living with HIV receiving antiretroviral therapy (%)	56	2018	Yellow	27.0	2018	Red	53	2018	Yellow
10万人当たりの結核感染者数 Tuberculosis incidence per 100,000 population	551	2018	Red	355.0	2018	Red	219	2018	Red
発熱した5歳未満児の適切な抗マラリア薬による治療を受けている割合 (%) Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs (%)	98.6	2018	Green	76.7	2016	Green	20.6	2017	Red
10万人当たりのマラリアによる死亡率 Malaria mortality rate (per 100,000 population)	48.9	2018	Yellow	43.6	2018	Yellow	48.9	2018	Yellow
顧みられない熱帯病に対する予防的な化学療法のカバレッジ (%) Coverage of Preventive Chemotherapy for Neglected Tropical Diseases (%)	72.8	2018	Yellow	25.3	2018	Red	64.6	2018	Yellow
心血管疾患、癌、糖尿病、又は慢性の呼吸器系疾患の死亡率 (30-70歳の成人 %) Age-standardised death rate due to cardiovascular disease, cancer, diabetes, or chronic respiratory disease in adults aged 30-70 years (%)	18.4	2016	Yellow	16.5	2016	Yellow	22.5	2016	Yellow
10万人当たりの道路交通事故による死亡率 Traffic deaths (per 100,000 population)	30.1	2016	Red	23.6	2016	Yellow	21.4	2016	Yellow
1,000人当たりの青年期 (15~19歳の女性) の出生率 Adolescent fertility rate (births per 1,000 adolescent females aged 15 to 19)	148.6	2017	Red	150.5	2017	Red	107.3	2017	Red
サービスカバレッジのユニバーサルヘルスカバレッジ (UHC) 指標 Universal health coverage (UHC) index of service coverage (worst 0-100 best)	46	2017	Yellow	40.0	2017	Yellow	42	2017	Yellow
10万人当たりの家庭内及び外部の大気汚染による死亡率 Age-standardized death rate attributable to household air pollution and ambient air pollution (per 100,000 population)	110	2016	Red	119.0	2016	Red	307	2016	Red
WHO推奨のワクチンのうち2種を接種して生存する乳児の割合 Percentage of surviving infants who received 2 WHO-recommended vaccines (%)	80	2018	Yellow	50.0	2018	Red	57	2018	Red
出生時平均余命 Life expectancy at birth (years)	60.1	2016	Yellow	62.6	2016	Yellow	55.2	2016	Yellow
主観的健康感尺度 Subjective well-being (average ladder score, worst 0-10 best)	4.9	2019	Yellow	3.8	2014	Red	5.3	2018	Yellow
ゴール4 : すべての人々への包摂的かつ公正な質の高い教育を提供し、生涯学習の機会を促進する Goal 4 Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all									
初等教育純就学率 (%) Net primary enrollment rate (%)	93.9	2018	Yellow	78.0	2011	Yellow	64.1	2010	Yellow
識字率 (15-24才 %) Literacy rate (% of population aged 15 to 24)	70.9	2017	Yellow	77.4	2014	Yellow	75	2018	Yellow
ゴール5 : ジェンダー平等を達成し、すべての女性及び女児の能力強化を行う Achieve gender equality and empower all women and girls									
近代的手法によって、家族計画についての自らの要望が満たされている出産可能年齢 (15~49歳) における女性の割合 (%) Demand for family planning satisfied by modern methods (% of females aged 15 to 49 who are married or in unions)	55.5	2015	Yellow	29.8	2016	Red	42.8	2018	Red
ゴール6 : すべての人々の水と衛生の利用可能性と持続可能な管理を確保する Ensure availability and sustainable management of water and sanitation for all									
安全に管理された飲料水サービスを利用する人口の割合 (%) Population using at least basic drinking water services (%)	55.7	2017	Yellow	55.8	2017	Yellow	71.4	2017	Yellow
基本的な公衆衛生サービスを利用する人口の割合 (%) Population using at least basic sanitation services (%)	29.4	2017	Yellow	49.9	2017	Yellow	39.2	2017	Red

出典: 2020 Africa SDGs Index and Dashboards と 外務省 Japan SDGs Action Platform

Source: 2020 Africa SDGs Index and Dashboards and Japan SDGs Action Platform, MOFA.

■ : Major challenges,
■ : Significant challenges,
■ : Challenges remain,
■ : SDG achieved,
■ : Information unavailable

Trends in Major Causes of Death at All Ages in Angola and Sub-Saharan Africa

Angola		Sub-Saharan Africa Average	
2010	2019	2019	
Respiratory infections and tuberculosis	17.4%	Respiratory infections and tuberculosis	14.0%
Maternal and neonatal disorders	11.7%	Cardiovascular diseases	13.1%
Enteric infections	11.5%	Maternal and neonatal disorders	11.2%
Cardiovascular diseases	10.0%	HIV/AIDS and sexually transmitted infections	9.1%
HIV/AIDS and sexually transmitted infections	7.5%	Enteric infections	8.9%
Other infectious diseases	6.5%	Neglected tropical diseases and malaria	8.3%
Neglected tropical diseases and malaria	5.8%	Neoplasms	6.8%
Transport injuries	5.1%	Other infectious diseases	4.4%
Neoplasms	4.7%	Digestive diseases	4.2%
Other non-communicable diseases	4.0%	Diabetes and kidney diseases	3.7%
Digestive diseases	3.7%	Other non-communicable diseases	3.7%
Nutritional deficiencies	3.1%	Unintentional injuries	2.6%
Unintentional injuries	2.6%	Transport injuries	2.4%
Diabetes and kidney diseases	2.4%	Chronic respiratory diseases	2.3%
Chronic respiratory diseases	1.8%	Self-harm and interpersonal violence	2.1%
Self-harm and interpersonal violence	1.2%	Nutritional deficiencies	1.4%
Neurological disorders	0.8%	Neurological disorders	1.4%
Substance use disorders	0.1%	Substance use disorders	0.1%
Skin and subcutaneous diseases	0.1%	Skin and subcutaneous diseases	0.1%
Musculoskeletal disorders	0.1%	Musculoskeletal disorders	0.1%
Mental disorders	0.0%	Mental disorders	0.0%

Source : Prepared by Survey team based on Institute for Health Metrics and Evaluation (IHME), GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington. Available from <http://vizhub.healthdata.org/gbd-compare>. (Accessed 2020.11.20)

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