

# WHO COUNTRY COOPERATION STRATEGY

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2015-2019

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ANGOLA

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### WHO Country Cooperation Strategy 2015-2019 Angola

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# WHO COUNTRY ANGOLA

## MAP



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# ACRONYMS AND ABBREVIATIONS

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<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ART</b>	Antiretroviral Therapy
<b>ARV</b>	Antiretroviral
<b>AU</b>	African Union
<b>CCS</b>	Country Cooperation Strategy
<b>CDC</b>	Centre for Diseases Control
<b>CECOMA</b>	Central Medical Stores
<b>CNCD</b>	Chronic Noncommunicable Diseases
<b>CPLP</b>	Community of Portuguese-speaking Countries
<b>CSST</b>	Centre for Occupational Health and Safety
<b>DSS/EMG/FAA</b>	Division of Health Services of the Angolan Armed Forces
<b>EHA</b>	Emergency and Humanitarian Action
<b>EPI</b>	Polio Eradication
<b>FAO</b>	United Nations Food and Agricultural Organisation
<b>FP</b>	Family Planning
<b>GAVI</b>	Global Alliance for Vaccines and Immunisation
<b>GEPE</b>	Studies, Planning and Statistics Office
<b>GSB</b>	General State Budget
<b>GDP</b>	Gross Domestic Product
<b>GPW</b>	General Programme of Work
<b>GSB</b>	General State Budget
<b>HAT</b>	Human African trypanosomiasis
<b>HDI</b>	Human Development Index
<b>HHA</b>	Harmonization for Health in Africa
<b>HIV</b>	Human Immunodeficiency Virus
<b>HRH</b>	Human Resources for Health
<b>HSS</b>	Strengthening Health System

<b>HSD</b>	Health and Sustainable Development
<b>ICC</b>	Interagency Coordination Committee for the Immunisation Programme
<b>IHR</b>	International Health Regulations
<b>IMCI</b>	Integrated Management of Childhood Illnesses
<b>INLS</b>	National AIDS Control Institute
<b>INSP</b>	National Public Health Institute
<b>JICA</b>	Japan International Cooperation Agency in Angola
<b>LLITN</b>	Long-Lasting Insecticide-Treated Bed Nets
<b>MAL</b>	Malaria
<b>MAPTSS</b>	Ministry of Public Administration, Labour and Social Security
<b>MDG</b>	Millennium Development Goals
<b>MDR-TB</b>	Multidrug-Resistant Tuberculosis
<b>MINSA</b>	Ministry of Health
<b>MSD</b>	Maternal Care and Safe Delivery
<b>NCM</b>	National Coordination Mechanism for the Global Fund
<b>NGO</b>	Non-Governmental Organisation
<b>NHDP</b>	National Health Development Plan
<b>NHP</b>	National Health Policy
<b>NMCP</b>	National Malaria Control Programme
<b>NPHD</b>	National Public Health Department
<b>NTCP</b>	National Tuberculosis Control Programme
<b>NTD</b>	Neglected Tropical Diseases
<b>ORPS</b>	Office of Research, Planning and Statistics
<b>PAV</b>	Vaccination Programme
<b>PMI</b>	Presidential Malaria Initiative
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission
<b>RBM</b>	Results-Based Management
<b>SADC</b>	Southern Africa Development Commission
<b>SNPC</b>	National Civil Protection Service
<b>STD</b>	Sexually Transmitted Diseases
<b>TA</b>	Technical Assistance

<b>TB</b>	Tuberculosis
<b>TRIP</b>	Trypanosomiasis
<b>UDT/UT</b>	Diagnosis and Treatment Unit/Treatment Unit
<b>UN</b>	United Nations
<b>UNAIDS</b>	United Nations Joint AIDS Programme
<b>UNCT</b>	United Nations Country Team
<b>UNDAF</b>	United Nations Development Assistance Framework
<b>UNDP</b>	United Nations Development Programme
<b>UNESCO</b>	United Nations for Education, Science and Culture
<b>UNFPA</b>	United Nations Population Fund
<b>UNGASS</b>	United Nations General Assembly Special Section
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>UNDP</b>	United Nations Development Programme
<b>WHO</b>	World Health Organization





# PREFACE

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The WHO Third Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly with a view to strengthen WHO capacity and make its deliverables more responsive to country needs. It reflects the WHO Twelfth General Programme of Work at country level, it aims at achieving greater relevance of WHO's technical cooperation with Member States and focuses on identification of priorities and efficiency measures in the implementation of WHO Programme Budget. It takes into consideration the role of different partners including non-state actors in providing support to Governments and communities.

The Third Generation CCS draws on lessons from the implementation of the first and second generation CCS, the country focus strategy (policies, plans, strategies and priorities), and the United Nations Development Assistance Framework (UNDAF). The CCSs are also in line with the global health context and the move towards Universal Health Coverage, integrating the principles of alignment, harmonization and effectiveness, as formulated in the Rome (2003), Paris (2005), Accra (2008), and Busan (2011) declarations on Aid Effectiveness. Also taken into account are the principles underlying the "Harmonization for Health in Africa" (HHA) and the "International Health Partnership Plus" (IHP+) initiatives, reflecting the policy of decentralization and enhancing the decision-making capacity of Governments to improve the quality of public health programmes and interventions.

The document has been developed in a consultative manner with key health stakeholders in the country and highlights the expectations of the work of the WHO secretariat. In line with the renewed country focus strategy, the CCS is to be used to communicate WHO's involvement in the country; formulate the WHO country workplan; advocate, mobilise resources and coordinate with partners; and shape the health dimension of the UNDAF and other health partnership platforms in the country.

I commend the efficient and effective leadership role played by the Government in the conduct of this important exercise of developing the CCS. I also request the entire WHO staff, particularly WHO Country Representative to double their efforts to ensure effective implementation of the programmatic orientations of this document for improved health outcomes which contribute to health and development in Africa.

Dr. Matshidiso Moeti  
WHO Regional Director for Africa

# EXECUTIVE SUMMARY

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The World Health Organisation (WHO) is executing a reform process with a view to becoming a United Nations agency tasked with leadership, methodological orientation and management of health systems at the global level. Accordingly, it aspires to be more dynamic and closer to Member State governments.

The changes being made under this reform process mainly relate to management of the Organisation, which has now adopted results-based programming (RBP), with the development and execution of a five-year General Programme of Work (GPW) and medium-term strategic plans.

The 12th WHO General Programme of Work defined the strategic vision of the Organisation for 2014–2019, based on the results achieved under the previous programme (11th GPW). In order to implement these programmes, a WHO Country Cooperation Strategy was designed (CCS), as a mechanism for supporting the policies and strategies of respective governments to enable them provide the highest possible quality of health to their peoples.

Angola recorded accelerated economic growth and invested heavily in infrastructure, because the government had defined a set of priorities aimed at combating hunger and poverty, through the promotion of inclusive and sustainable human development.

The third edition of the CCS has two principal objectives namely: to improve the quality of WHO technical assistance in the current context of the country's socioeconomic and health development; and to assess the implementation of the previous strategy.

The implementation of the second country cooperation strategy (2008-2013) was extended to late 2014, in order to make it consistent with the current duration of the government's strategic plan which ends 2017. This made it possible to provide more structured support to the Ministry of Health in reinforcing the execution of strategic policies and plans, monitoring and evaluation and implementation of ongoing programmes, starting with the first edition of the CCS in 2006.

For the new cooperation strategy, the Global and Regional Health Agenda will set the guidelines for WHO assistance. This Agenda will be aligned with the 2012-2025 National Health Development Plan (NHDP) and the 2013-2017 National Development Plan (NDP).

The 3rd Cooperation Strategy was drafted through a participatory approach, involving the management of the Ministry of Health, officials and professionals from other ministries that contribute to health development, health training institutions, private sector professional associations and NGOs.

It was a dynamic and productive process, and valuable contributions were made to strengthen the CCS over the next five year period. The process highlighted the need to: redouble support to health sector academic and research institutions; evaluate the quality of training provided to health professionals; monitor and evaluate the performance of health teams in maternal and child care; combat disease; and improve the management of services under the municipal health system defined by the Ministry of Health as the country's basic health development unit.

Similarly, mechanisms should be identified under the new strategy to reinforce the support given to Ministry of Health teams for the coordination, monitoring and evaluation of the implementation of International Health Regulations (IHR), as the instrument guiding integrated surveillance and response to epidemics, with a view to curbing overall mortality within the population.

To achieve good results under the new CCS, it will be necessary to improve the synergy among Ministry of Health teams, WHO (at the 3 levels) and other health sector stakeholders in Angola.

WHO will continue to support the Government of Angola in health system decentralisation, by developing and operationalizing provincial and municipal health development plans.

Budget plans and allocations should, in priority, be aligned with cross-cutting interventions, such as health promotion and development of health systems and services (including training, research and health information system), especially for the monitoring of standard operating procedures for public health actions at the peripheral (municipal) level.

# SECTION I:

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## INTRODUCTION

Over the last five years and as part of the on-going reform process aimed at improving the agency's working methods, the WHO Programme of Work has been guided by the need to provide more effective support to Member States as they strive to tackle their major health and development challenges.

As defined in the 12th General Programme of Work (2014-2019) which covers the next five-year period, the principal mission of WHO is *"to act as the directing and coordinating authority on international health work ... with the objective of guaranteeing the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being"*.

With regard to attainment of this objective, the Country Cooperation Strategy (CCS), prepared through the participatory approach that characterizes the work of WHO at country level, continues to be recognised as a valuable cooperation instrument, for both WHO teams and Member Country teams.

The 2009-2013 cooperation strategy was appraised at a meeting held in Sumbe, Kwanza Sul Province from 2 to 4 October 2013, for professionals and officials from the Ministry of Health and the WHO country office in Angola. Meeting participants reviewed the progress made, problems and constraints encountered, lessons learned, best practices and the coherence of implemented actions in terms of the extent to which national health policies are consistent with WHO regional and global guidelines.

The peace enjoyed by the country over the past 12 years has yielded significant progress in the management of the national health system, in key areas such as maternal and child health as well as communicable disease control, thus boosting national health development.

Nonetheless, some challenges remain, especially in the reduction of maternal and child mortality and in communicable and noncommunicable disease control. The actions required to tackle these challenges include: focusing on maternal and child health; preventing mother-to-child transmission of

HIV; curbing vaccine-preventable diseases; and reducing the incidence of tuberculosis, malaria and neglected tropical diseases.

Similarly, national health system strengthening, preparation and rapid response to epidemics as well as national and international public health threats, and the promotion of health and healthy environments remain the key challenges.

The country has maintained its resolve to attain the Millennium Development Goals (MDG) and made progress in the implementation of the International Health Regulations (IHR) 2005 and other regional and global conventions.

The WHO five-year Country Cooperation Strategy with the Government of Angola for 2015–2019, was drafted by Ministry of Health teams in conjunction with major health and development stakeholders such as NGOs, academia, civil society organisations, etc. The new strategy seeks to build on the gains of the previous strategy (2009-2013) and is consistent with the strategic objectives of WHO reform, the guidelines contained in the United Nations Partnership Framework with the Government of Angola (UNPAF), the objectives outlined in the National Country Development Strategy (Angola 2025) and the priorities defined in the National Health Development Plan (NHDP) 2012–2025.

In this exercise, special attention was given to strategies for strengthening the health sector institutional framework and improving service provision by the Municipal Health System. Mechanisms were identified to reinforce the support given to Ministry of Health teams for coordination, monitoring and evaluation of cooperation.

Technical assistance will be strengthened to: improve access to medicines and other medical supplies; define health financing mechanisms; update national health accounts; and address the social, economic and environmental determinants of better health for the Angolan population.

# SECTION 2:

## ECONOMIC, SOCIAL AND HEALTH DEVELOPMENT CHALLENGES OF THE COUNTRY

### 2.1. Principal demographic characteristics of the population

Like most developing countries, Angola has a relatively youthful population. The demographic indicators are a challenge to the country's sustainable development. According to the 2012–2025 NHDP and the UNDP statistical indicators included in the 2014 Human Development Report, the population is estimated at about 24.3 million inhabitants<sup>1</sup>, with a high annual growth rate of about 3.0%. Some 55% of the population lives in urban and peri-urban areas while 45% lives in rural areas. There is an internal migratory movement of about 20% from the rural to the peri-urban areas.

The national population is estimated to comprise 48% men and 52% women. Under-5 children account for 15% of this population while those under the age of 15 years account for 48%. Moreover, 47% of the inhabitants dwell in urban areas while 49% are in rural areas. Only 50% of the population is economically active and a large number is dependent on the State and their families.

Women of child-bearing age (15 – 49 years) account for approximately 44% of the female population and the fertility rate is 6.4 children per woman (down from 7.2 per woman in 2005).

An average family unit is made up of 5 persons and one in five families is headed by a woman. The average life expectancy at birth is 52 years (51 years for men and 53 for women).

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<sup>1</sup>Censo nacional de população 2014

## 2.2. Macroeconomic, political and social context

In the last decade, the economy of Angola experienced robust growth, mainly driven by the petroleum sector which generated 55% of the GDP and 95% of exports. Angola's economic growth rate is considered to be one of the highest in the world, with an average annual GDP growth rate of 9.2% over the last 5 years. The rural sector, comprising agriculture, tree farming, stockbreeding and small-scale fishing, is the second most productive sector, accounting for approximately 8% of GDP up to 2010.

The informal sector is quite enormous, particularly in semi-urban areas, although its exact size has not yet been determined. A series of macroeconomic measures are being taken within the framework of poverty reduction programmes to integrate informal sector stakeholders into the formal economy.

Until 2009, the reorganized non-oil sector included agriculture, industrial fishing, construction, trade, industry, hotel industry and tourism, as well as telecommunications. These sectors had the potential to employ a large proportion of the economically-active population and improve family incomes (National Health Policy - NHP 2010).

**Table 1:** GDP trends for 2009-2012

<b>GDP (at current prices)</b>				
	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Fishery and by-products	14,5	16,9	22,1	26,5
Diamond and others	53,7	71,1	89,1	85,8
Oil	2.661,6	3.401,0	4.640,8	4.981,0
Processing industry	363,8	464,2	584,3	726,3
Construction	449,6	601,6	750,6	914,1
Energy	7,4	9,5	11,0	13,2
Commercial services	1.240,4	1.555,1	1.896,0	2.344,2
Others	454,0	548,2	669,0	790,3
<b>GDP at factor cost</b>	<b>5.841,5</b>	<b>7.396,8</b>	<b>9.549,3</b>	<b>10.630,3</b>
<b>GDP at market prices</b>	<b>5.988,7</b>	<b>7.584,6</b>	<b>9.780,1</b>	<b>10.876,0</b>

Source: Ministry of Planning and Territorial Development, 2014 ([www.mpd.gov.ao/](http://www.mpd.gov.ao/))



Table 1 shows an increase in GDP at market prices from 5,988.7 to 10,876 billion kwanzas, between 2009 and 2012. It reflects the significant expansion of the GDP by the various economic sectors, especially oil, commercial services, construction and agriculture.

Over the last 5 years, the non-oil sector nearly doubled with an average growth rate of 12%, owing to the boom in activities within the construction, agriculture and commercial services sectors. The following results were achieved in each sector during the 2009-2011 period.

**a) Economic sector:** The products and services that experienced robust growth were: coffee (43%); cereals (+34%); vegetables (30%); fruits (27%); inland fishing (311%); industrial fishing (197%); beverages (44%) and tourism (34%). The sectors that recorded a decline were: traditional fishing (-47%); ornamental rocks (-31%); diamond (-11%) and oil (-8%) (Source: NDP 2013-2017).

**b) Infrastructure:** The activities that recorded the best performance were: internet services (369%); installation of telephone lines (153%); mobile telephony (46%); hydropower (23%); energy distribution (16%); construction of water fountains (21%) and construction of water points (9%). Transport recorded a decline in both freight and passenger flows. (Source: NDP 2013-2017).

**c) Social:**

- **Education:** There was a huge increase in the student enrolment in non-university establishments (15%); an improvement in the gross enrolment ratio (29% in 3 years); an increase in the number of classrooms (9%); rapid growth in higher education student enrolment (68%) and teaching staff (21%); and a surge in the number of internal scholarships (200%) and external scholarships (21%) (Source NDP 2013-2017).
- **Legislation:** There was an increase in the number of female judges (9%) and judicial officers (7%). (Source NDP 2013-2017)
- **Social Aid:** Given the sharp increase in the number of State dependents: the number of aid recipients increased sevenfold while the number of war veterans receiving a pension increased by 6%. (Source PND 2013-2017).
- **Health:** The municipalisation of health services has been initiated,

with provincial governors and directors and municipal teams actively taking the lead. There has been a significant increase in the number of rehabilitated and newly-built health posts and centres, and in activities relating to continuing education, supervision of health units, monitoring of activities and presentation of results.

- **Sports:** The number of persons who practise sports has increased five-fold. (Source NDP 2013-2017).

All the above notwithstanding, some indicators have regressed and require special and urgent attention. These include: an increase in the number of cases of malaria (21%), AIDS (127%) and typhoid fever (95%); an increase in the school dropout rate (from 8.8% to 15.5%) and a decline in the school performance rate (from 78% to 72%); a sharp fall in the number of readers using the national library (-25%); and a significant drop in the number of museum visitors (-23%) (National Development Plan 2013 - 2017, pg. 22).

- **Millennium Development Goals:** In spite of government investment in universal primary education and the promotion of equal opportunity to ensure the personal development of both men and women, there are still major obstacles to the attainment of more equitable and sustainable human development in a context of inclusive economic growth. (UNPAF 2015-2019).

The last UNDP Human Development Report of July 2014 ranked Angola in the 149th position out of 187 countries, with a human development index (HDI) of 0.526, compared to 0.377 in the year 2000. These data show that the country needs to continue receiving development assistance.

Angola is implementing reforms in various areas, including health, the judiciary and the tax system. Health sector reforms cover both legislative and organisational aspects while tax reform envisages a reduction in taxes, expansion of the tax base and more efficient tax collection. At the political level, the country has embarked on democratisation and is conducting parliamentary and presidential elections. However, planning is on-going for the creation of local authorities with a view to consolidating the decentralization of the administration.

## 2.3. Health sector challenges

Table 2 and Graph 1 below show that GDP more than doubled from 5,803,484 million kwanzas to 12,713,235 million kwanzas, between 2009 and 2014. At the same time, the general State budget more than tripled from 2,020,352 million kwanzas to 7,258,385 million kwanzas, during the same period (2009 to 2014). Furthermore, the general State budget, as a percentage of GDP, surged from 24.80% in 2009 to 57.10% in 2014.

It is evident that total health expenditure, in absolute terms, more than tripled from 100,121 million kwanzas in 2009 to 346,734 million kwanzas in 2014. This significant increase in total health expenditure corresponds to a variation of 1.7% to 2.7% of GDP. However, total health expenditure, as a percentage of the general State budget, remained relatively stable at an average of 4.58% during the same period.

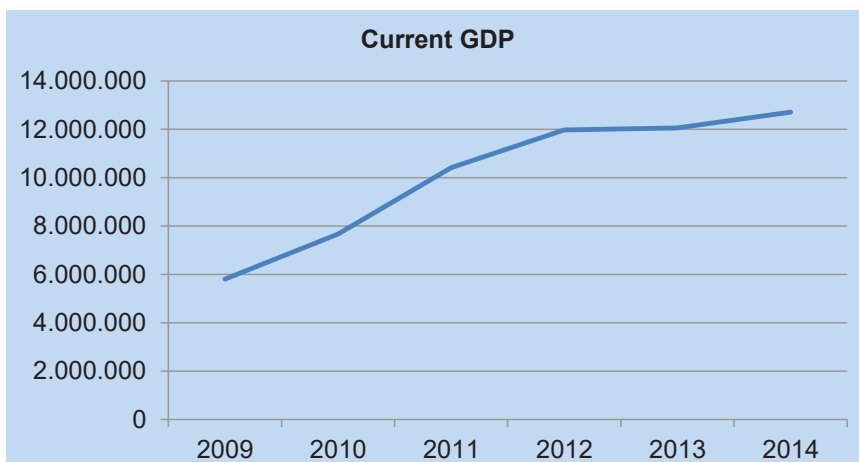
This increase in health expenditure is an opportunity to significantly enhance health sector performance and improve the health status of the population.

**Table 2:** GDP, total public expenditure and health expenditure (in millions of kwanzas and in percentages)

	2009	2010	2011	2012	2013*	2014*a
<b>Current GDP</b>	5,803,484	7,662,130	10,416,478	11,974,557	12,056,343	12,713,235
<b>Total GSB</b>	2,020,352	3,179,373	4,310,706	4,498,917	6,119,730	7,258,385
<b>Total Health</b>	100,121	117,093	176,699	213,098	317,507	346,734
<b>% GSB in GDP</b>	34.80%	41.50%	41.40%	37.60%	50.80%	57.10%
<b>% Health in GDP</b>	1.70%	1.50%	1.70%	1.80%	2.60%	2.70%
<b>% Health in GSB</b>	5.00%	3.70%	4.10%	4.70%	5.20%	4.80%

Source: Public Health Sector Expenditure 2002-2014 (Provisional) ORPS of MINSA. (a) 2014 is budget estimates, not actual expenditure.

**Gráfico 1:** Current GDP trends in Angola (in millions of kwanzas)



Source: Public Health Sector Expenditure 2002-2014 (Provisional) ORPS of MINSA

Table 3 and Graph 2 below show that the health budget increased considerably, from 153 million kwanzas in 2009 to 346 million in 2014. It also shows a significant increase in the execution of the general State budget (GSB) from 65% in 2009 to 91% in 2013, stemming from the growing absorption capacity of the health sector.

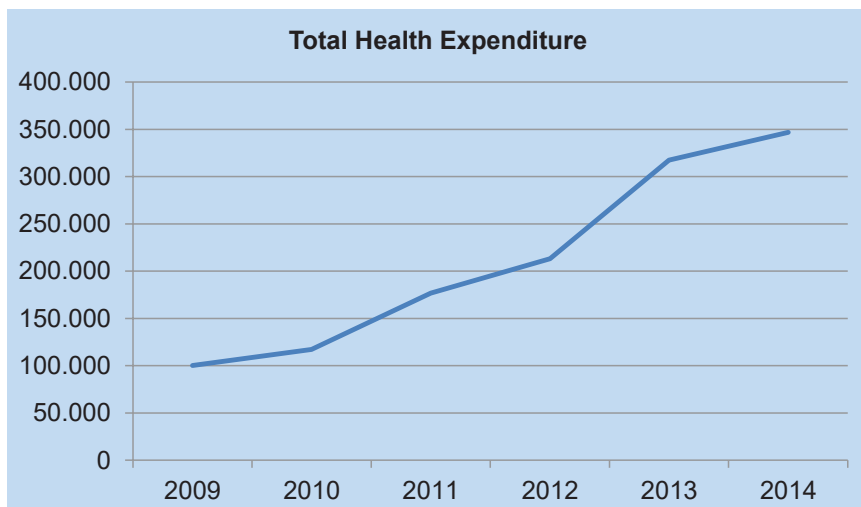
However, persistent problems, such as the poor quality and limited supply of human resources needed for the implementation and management of programmes, as well as the non-transfer of financial resources to the primary level, could undermine the steady improvement of execution capacity.

**Table 3:** Budget and total public expenditure including health (in millions of kwanzas)

	2009	2010	2011	2012	2013	2014 (a)
<b>Health budget</b>	153,913	134,060	184,416	213,492	348,869	346,734
<b>Actual health budget execution</b>	100,121	117,093	176,699	213,098	317,507	N/D
<b>Execution rate</b>	65.1%	87.3%	95.8%	99.8%	91.0%	N/D

Source: Public expenditure in health sector 2002-2014 (Provisional) ORPS of MINSA

**Graph 2:** Total health expenditure trends (in millions of kwanzas)



Source: Public expenditure in the health sector 2002-2014 (Provisional) ORPS of MINSA

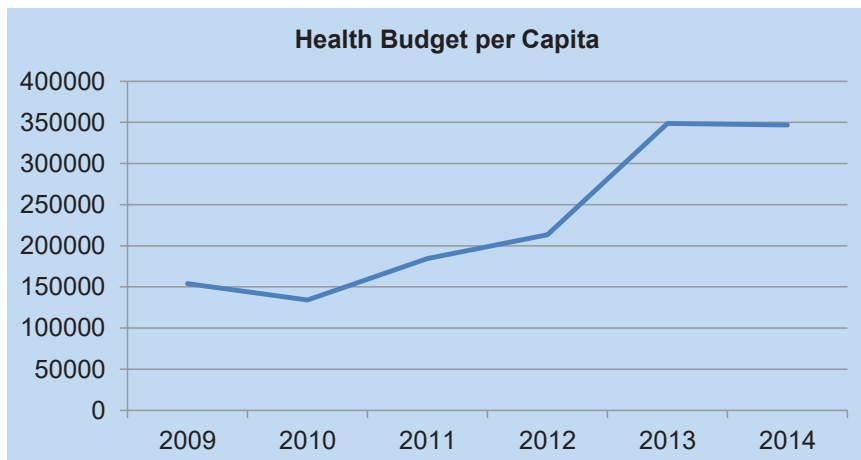
The data in Table 4 show that the budget per capita doubled, from 7,247 kwanzas in 2009 to 14,220 kwanzas in 2014. Similarly, expenditure per capita tripled, from 4,714 kwanzas in 2009 to 13,386 kwanzas in 2014.

**Table 4:** Public budget and expenditure on health per capita (in kwanzas)

	2009	2010	2011	2012	2013	2014 (a)
Health budget per capita	7,247	6,140	8,216	9,253	14,708	14,220
Health budget expenditure	4,714	5,363	7,873	9,236	13,386	N/D

Source: Public Expenditure on the Health Sector 2002-2014 (Provisional) ORPS of MINSA

**Graph 3:** Health budget per capita trends (in kwanzas)



Source: Public Expenditure on the Health Sector 2002-2014 (Provisional) ORPS of MINSA

The major health sector challenges in Angola, as at the time of preparation of this document, can be summed up as follows:

- High communicable disease mortality and morbidity, frequent epidemics and a sharp rise (as yet unmeasured) in the prevalence of noncommunicable diseases;
- Increased vulnerability of the country to various potentially health-threatening situations due to the high mobility of persons and goods, intensive commercial activities within and outside the country, and extensive open borders shared with neighboring countries;
- Limited basic capacity and inadequate legislative mechanisms within the national health system to implement key national and international preventive and control measures on public health;
- Reduction in the maternal and child mortality index;
- Guarantee of continuous training, sustainable quality human resources and good quality health services;
- Coordination and pooling of efforts within and between sectors that positively influence the social and economic determinants of health.

During the interactive sessions on the contribution of health workers to national health development, held between June and August 2014, the following difficulties were identified in the exercise of their duties:

- No systematic mapping of regions, localities, and vulnerable and/or at-risk populations to facilitate timely response through selected interventions;
- Difficulties in harmonizing and using health information generated and disseminated by various health sector stakeholders;
- Poor management of health services at the peripheral level, and of the referral and counter-referral system in the provision of health care to the population;
- Weak linkage between health and environmental programmes and actions, within the framework of disease prevention and control;
- Limited capacity of national institutions to prevent and treat chronic noncommunicable diseases;
- Diversity and sheer disparity of procedures for training human resources at the peripheral level to execute tasks relating to the implementation of health strategies developed at the central level;
- Limited specific interventions for building the technical capacity of nursing professionals and other auxiliary health care personnel;
- No timely assessment of the scope and quality of work done by NGOs in implementing the health strategies developed at the provincial and central levels;
- Poor access to primary health care provided through primary health center, particularly in suburban and rural areas, and limited supply of qualified human resources.

## 2.4. Other determinants of health

About 36% of the population currently lives below the poverty line and has limited access basic public services (water, sanitation, energy, health, education and housing).

In the education sector, UNESCO rates Angola as a country with a low Education for All Development Index (EDI), placing it in the 111th position out of 120 countries in its 2012 Education-for-All rankings, with a value of 0.685 and a gender-specific EFA index of 0.734 (UNESCO 2010).

Between 2008 and 2013, several international agencies such as the Committee on Economic, Social and Cultural Rights (CESCR), the Committee on the Rights of the Child (CRC) and the Committee on the Elimination of Discrimination against Women (CEDAW), expressed concerns about enforcement of the right to education for all Angolans.

In spite of the significant progress achieved in recent years, there are still complex challenges in various areas such as management, access, equity and quality of teaching at all levels.

There are disparities in community development between regions and high population pressure in urban areas, due to the lack of equal opportunities. This has triggered internal migratory flows towards urban areas, and overburdened available public services and infrastructure, thereby undermining the country's socio-economic and human development (UNPAF 2015 – 2019).

## 2.5. Health status of the population

Despite declining from 205/1000 live births in 2007 to 164/1000 live births in 2013, the child mortality rate remains high relative to the African average of 127/1000 live births. Neonatal and maternal mortality estimated at 42/1000 and 470/1000 live births respectively, also remain high (WHO Observatory Report, 2013)

In 2013, the highest specific lethality rates were recorded, in decreasing order, as follows: human rabies 100%, tetanus 28.3%, meningitis 13.0%, malnutrition 4, 1%, AIDS 3.8%, cholera 3.2%, hepatitis 2.7% and tuberculosis 2.6% (MINSa, 2013 Report).



**Malaria** accounts for approximately 35% of curative care, 20% of hospital admissions, 40% of perinatal deaths and 25% of maternal mortality (DNSP, 2013 Annual Report and PNCM- DNSP, IIMA Report 2011). It remains a major public health concern in Angola, being the leading cause of death, disease and absenteeism from work and school. In 2010, about 3.7 million suspected cases of malaria were reported, and in 2013, 2,487,306 cases and 6,518 deaths were recorded.

**Tuberculosis** had a negative impact on community health and development, affecting mainly the labour force (15 to 39 years). The annual incidence of pulmonary tuberculosis increased from 2009, peaking at 277 cases/100,000 inhabitants in 2013. Similarly, tuberculosis prevalence (for all strains) increased from 2009, and reached 340.1 cases/100,000 inhabitants in end-2013, reflecting a surge in the number of cases of multidrug-resistant tuberculosis and co-infection with HIV. This situation places Angola among high risk countries, and is therefore considered a major public health problem with negative consequences on the country's economy (NTCP - NPHD, 2013 Annual Report).

The **HIV epidemic in Angola** is widespread with a steady prevalence rate of 2.4% and a relatively higher rate in pregnant women (3%). Data is scarce on the population that is more vulnerable to the disease, but available data indicates higher prevalence within some specific groups (women and youths who are commercial sex workers, men who have sex with men). In a study on HIV/AIDS prevalence in pregnant women, conducted in 2011, it was observed that prevalence varied, with eleven provinces ranking above the national average<sup>2</sup>.

The following results were obtained for neglected tropical diseases:  
The number of recorded cases of human African trypanosomiasis (AHT) plummeted from 8275 in 1997 to 69 cases in 2013.

\* **Leprosy** ceased to be considered a national public health problem by 2005, when the prevalence rate fell to less than one case per 10 000 inhabitants.

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<sup>2</sup> Source: Study on sero-prevalence among pregnant women in 2011, Ministry of Health, 2014. Progress Report, 2013.

With regard to the mother-to-child transmission rate, SPECTRUM estimates show a steady decline from 33.5% in 2011 to 30.5% in 2012, and 25.4% in 2013, when PMTCT ARV coverage for pregnant women was 39.19%. The increase in PMTCT ARV coverage contributed to a progressive reduction in the PMTCT rate. In Angola, ARV coverage rose from 36% in 2011 to 47.1% in 2013 (among children and adults, including pregnant women) (SPECTRUM data, 2013).

However, a prevalence rate above the national average has been recorded in some provinces. Available information from the National Public Health Department shows that 378 new cases were recorded. The prevalence recorded in 2013 was 1141 cases, which is consistent with the elimination target (0.6 cases/10 000 inhabitants) (NPHD 2013 Annual Report).

\* ***Onchocerciasis*** is still endemic in 44 municipalities in 9 provinces. The mappings produced between 2004 and 2011 show that 3,240 communities are affected and approximately 2.5 million persons are at risk, thus requiring mass treatment.

\* ***Geo-helminthiasis, schistosomiasis, lymphatic filariasis and loiasis*** are equally endemic in the country, with the North, Central and Eastern provinces being the most affected. It is estimated that more than 12,000,000 people are at risk of contracting these diseases (NHDP 2012 - 2025, pg. 27).

## 2.6. Maternal and child health

The identified direct causes of maternal mortality are post-partum hemorrhage, pre-eclampsia/eclampsia, puerperal infections, ruptured uterus and unsafe abortion, whilst the indirect causes are malaria, hepatitis and anaemia. Operational research is on-going on the use of Misoprostrol/Citotec to improve the treatment of obstetric hemorrhage resulting from abortion.

Childhood diseases account for most infant and child mortality, the most frequent being:

- **Acute respiratory disease, which** has an incidence rate of 4,722.8/100 000 inhabitants and accounts for 20.6% of all cases and 11.1% of all deaths recorded in the country. The most affected age groups are children within the 1-4 years age bracket (25%), followed by neonates (19.7%), thus making this disease the second leading cause of under-five deaths (NHDP 2012-2025).
- **Acute diarrheal illness**, which had an incidence rate of 2037/100 000 inhabitants in 2013, mainly affecting children within the 1-4 years age bracket (31.4%) and being the third leading cause of under-five deaths (NHDP 2012-2025).

- **Meningitis** is one of the main causes of hospital mortality. In 2013, 529 cases were notified, with a lethality of 18%. One-third of meningitis cases occur in under-five children. Angola has localities at high risk of meningococcal serotype A meningitis, that have experienced large-scale epidemics in the past.
- **Measles** continues to be a public health problem, in spite of progress made in routine immunization, because it is a major cause of under-five morbidity and mortality, and also affects older children and adults. Over the last 10 years, there has been a continuous transmission pattern, with epidemic outbreaks of varying magnitude every 2 or 3 years, in nearly all municipalities. In 2013, 8,777 cases were notified and confirmed by the Ministry of Health. Lethality during the outbreaks was between 5 and 9% (MINSa-EPI data base).
- In 2013, 360 tetanus cases were reported, corresponding to an incidence of 1.6/100 000 inhabitants and a lethality of 28%. In spite of the country's efforts to eliminate neonatal tetanus, there was an increase of 33 cases in 2013, with an incidence of 0.03/1000 live-births. It is believed that cases are under-reported, particularly in the rural areas (2013 JRF Report).
- Chronic malnutrition affects about 15.6% of Angolan under-five children. It is considered a secondary cause of mortality in two out of every three deaths within this age group. Periodic droughts in some parts of the country aggravate the problem of nutrition, particularly in younger children (Nutritional survey 2007).

Over the last 3 years, epidemics of malaria, diarrhea (bloody stool and viral), cholera, measles, human and animal rabies, dengue fever and chikungunya have been notified, investigated and controlled. The country is currently on maximum alert and special surveillance and preventive measures are being taken with respect to the Ebola epidemic afflicting the African continent.

Communicable diseases still account for more than 50% of deaths recorded within the population. The situation is worsened by the high prevalence of malnutrition among under-five children and the exponential increase in recorded cases of chronic non communicable diseases (CNCD).

Increased mortality from road accidents is a cause for concern. It is now the second cause of death in the country, aggravated in large part by alcohol

and drug abuse, which also fuel the increase in cases of violence (especially domestic violence) in the country (Law No. 25/11 of 14 July 2011 against domestic violence).

## 2.7. National Response to development challenges

Cognizant of its responsibilities, the Government of Angola has recognized the need to adopt a global and integrated response to the socioeconomic challenges identified. Consequently it approved the following strategies for implementation:

- **Long term development strategy, known as “Angola 2025”,**

The main objectives of this strategy are to *eliminate hunger and extreme poverty and reduce development disparities* between the various regions of the country. The major guidelines of this national strategy include: public policies to eradicate hunger and reduce poverty as a degrading social ill, and the control of disease and illiteracy as barriers to socio-economic development. These are determinants that have a clear impact on the health status of the population and, consequently, on the socioeconomic development of nations

- **National Development Plan (NDP) 2013-2017.**

This document outlines the macroeconomic reference framework for the 2013-2017 period, and also defines and formalizes the fundamental assumptions that should guide the drafting of short and medium term planning instruments, in line with Presidential Order No. 08/2012 of 2 May 2012.

It also establishes the Medium Term Development Expenditure Framework, including the 2013-2017 Fiscal Framework, the national Staff Training Plan and the National Plan and General State Budget for 2013.

If they are fully and appropriately implemented, these strategic guidelines would not only help to generate more national wealth but also guarantee the participation of individuals, families and community leaders in the implementation of public policies and, in particular, the promotion and protection of personal and public health.

## 2.8. Response of the Ministry of Health to health challenges

The sector's response to the identified challenges is set forth in the national health policy, the 2012-2025 National Health Development Plan and in the strategies of the various health programmes,

### National Health Policy

The National Health Policy approved in 2010 as the guiding document for all the country's health activities, defines the main strategic guidelines for health development up to 2025. It seeks to guarantee the provision of an essential health care package, mobilize communities, strengthen partnerships and promote health.

The restructuring and development of the National Health System gives priority to guaranteeing access to primary health care for the entire population by strengthening the municipal health system, focusing on the following components:

- **Organization, management** and revitalization of services at the municipal level, with emphasis on universal access, efficiency, capacity to address identified health problems, quality of services rendered, and financial protection for the most vulnerable, in accordance with regional commitments to implement the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa.
- **Human resource availability, quality and performance at the municipal level** – providing training for new professionals, adopting measures and mechanisms to reduce geographical inequality and deploying professionals to the peripheral levels.
- **Provision of medicines as well as health infrastructure and technology**, giving priority to the adoption of legislation, regulations and technical standards for the production, procurement, storage, distribution and rational use of medicines, and pharmaceutical surveillance.
- **Sustainable financing of health services with provision for a progressive increase in the health sector allocation** within the

general State budget (GSB) from 3.5% in 2005 to 5% in 2025.

- **Development of the Integrated Health Information System**, including a communications network, in order to ensure the flow of routine information within the national health system.
- **Health research and development** - as one of the basic tools for generating knowledge on existing health problems within communities and adapting public policies accordingly.
- **Leadership and governance**, to coordinate other sectors and establish linkages between interventions which impact on health determinants.

## National Health Development Plan 2012 - 2025

The key priorities of the National Health Development Policy are consistent with the National Long Term Strategy, termed “Angola 2025” and with the 2013-2017 National Development Plan. These priorities are geared towards: (i) combating disease; (ii) providing health care to communities; (iii) developing a human resources management model; (iv) developing a financing model; and (v) developing a national health system organization and management model.

Reorientation of the national health system management model requires that absolute priority be given to primary health care (PHC) and relative priority given to Level 2 of the NHS. It further requires that by 2015, the provincial hospital network and the network of central general hospitals be rehabilitated (NHDP 2012 – 2025, pg. 32).

The major priorities of the national health system are to reduce maternal and child mortality, control communicable and non-communicable diseases, ensure the adequacy of human resources and health technology, guarantee sustainable financing and promote the efficient management of health system resources, with emphasis on the following interventions:

- Definition and availability of an **Essential Health Service Package**, with focus on reproductive health and integrated management of childhood illnesses (IMCI);
- Establishment of a referral and counter-referral system, as well as the **optimization of essential obstetric and pediatric care**;

- Execution of preventive actions, including vaccine-preventable diseases and coverage of the standardized and appropriate diagnosis and treatment of malaria, **HIV/AIDS**, tuberculosis and sleeping sickness;
- Mobilization of communities for health promotion and protection;
- Promotion and preservation of a general context and an environment that are both conducive to health, based on the implementation of the Libreville Declaration on Health and Environment in Africa.

The Integrated Survey on the Welfare of the Population (IBEP), conducted in August 2010 in Angola, revealed that progress towards achievement of the Millennium Development Goals was below 50%.

The implementation of on-going public health strategies yielded the following results:

- **Protection of Maternal and Child Health**

In Angola, the maternal mortality rate, estimated at 1400 per 100 000 live births in 2000, declined to 610 in 2008 and 450 in 2010.

There has been a progressive reduction in the maternal mortality rate from 1400/100 000 live births in 2000 to 450/100 000 live births in 2010.

With respect to the maternal health indicators, the fertility rate declined from 7.2% in 2001 to 6.9%; the contraceptive usage rate surged from 6.6% to 17.7%; deliveries assisted by professional birth attendants increased from 36% to 49% while prenatal coverage is 69% for one or more visits. The tetanus vaccination coverage in women of childbearing age is 80%, IPT coverage in pregnant women is 42% and that of prevention of mother-to-child transmission of HIV is 20% (NHDP 2012-2025).

In 2013, the National Public Health Department (NPHD) estimated the institutional maternal mortality rate at 315/100,000 live births and the prevalence of contraceptive use at 8.6% (2013 Annual Report). However, the latter indicator showed a variation of 6.6% in 2001 (MICS-I), compared to 17.7 % in 2010 (IBEP).

Over the last five years, the neonatal mortality rate declined to 42/1000 live births; the infant mortality rate was 116/1000 live births while under-five mortality was 195 /1000 live births (NHDP).

Immunization coverage also improved, rising steadily from 81% in 2009 to 93% for Penta 3 in 2013, and from 79% to 91% for measles during the same period (Source: JRF 2009 and 2013).

At the moment, barely 65% of health facilities provide routine immunization services, and they do so using mobile advance teams. As a result, the services are more costly and this undermines the sustainability of the immunization coverage already achieved. Consequently, complementary strategies need to be introduced in order to improve routine coverage across the entire national health network (public and private).

With regard to child health, mass administration of vitamin A and albendazole has been integrated into routine immunization activities as well as in polio and/or measles immunization campaigns. During the 2013 campaign, coverage reached 84% for vitamin A and 83% for albendazole.

There is an on-going in-service training programme for municipal health workers, including pediatricians, in 7 provinces. In response to the drought which affected some regions in 2012–2013, some 2,016 community workers were trained to detect and treat malnutrition within the community, and assistance was provided to 1,087,603 children in 7 provinces, namely: Bié, Huambo, Kwanza-Sul, Zaire, Huíla Benguela and Cunene (NPHD, 2013 Report).

- **Disease Control**

Ongoing interventions for **malaria** control, evaluated through the survey on the status of malaria indicators in 2011, indicate that about 40% of households possess one long-lasting insecticide-treated bed net (LLITN) or had their houses sprayed in the 12 months preceding the survey. The figures are 15% for the poorest households and 50% for households in the richest quintile.

According to the survey on malaria indicators conducted in 2011, prevalence fell from 21% in 2006, to 13% in 2011, representing a 30% decline (NDP, pg. 34).



On tuberculosis control, health care for TB is provided mainly at the municipal level, whose scope is still insufficient for such services. This makes access to diagnosis and treatment difficult for communities located far away from provincial headquarters.

The current operational TB network covers 194 health facilities which notify TB cases, of which only 95 conduct KB testing. Some 118 municipalities in 18 provinces, or 73.2% of all the 161 municipalities, have diagnosis and treatment units or treatment units (NTCP- NPHD and ORPS /MINSA Data, September 2013).

In 2013, a total of 39,225 new cases and 1123 abandoned cases were notified, with the corresponding risk of occurrence of multidrug-resistant tuberculosis.

Of the 12,592 KB-positive new cases detected in 2013, some 1612 or 12.8% were HIV-positive. A network of 148 HIV/AIDS services is currently operational.

The NTCP and INLS teams are deploying all efforts to respond to cases of TB/HIV co-infection, in line with the country's commitment to the UNGASS goals (Annual Report of the National Tuberculosis Control Programme, NPHD 2013).

The **control of HIV transmission** within the various communities is coordinated by the National AIDS Control Institute (INLS). In the 2003–2013 decade, 904 counselling and testing (CT) center were established. During this period, 3,498,102 patients were screened, of which 5.3% tested positive for HIV.

Between 2004 and 2013, some 419 units were established to provide care to HIV-positive pregnant women, under the prevention of mother-to-child transmission (PMTCT) programme. In 2013, 492,348 pregnant women were tested during ante-natal consultations, of which 2.3% were positive.

Using mobile clinics, 954,282 tests were carried out, of which 4.7% were HIV positive. Of the 436,477 HIV tests carried out on the adult population, 7.2% were positive. Of the 25,457 children tested, 8.7% were positive.

**Support and ART for Children:** During the period under review, support was initiated for a total of 2,225 children, of which 47% were started on ART.

On HIV/AIDS mortality for the 13,058 patients placed on ART (12,012 adults and 1,046 children), 788 (6.5%) adults and 211 (20.1%) children died (INLS, 2013 report).

## **Development of health systems and services**

The health system in Angola is based on the Primary Health Care and Hospital Assistance Programme, which covers health services from the community level right up to a more complex level. It comprises 5 sub-programmes, namely: (1) promotion of healthy habits and lifestyles; (2) operationalization of health care services; (3) safe blood transfusion; (4) management and development of the national laboratory network; and (5) pre-hospital assistance. The health needs and problems currently encountered by the NHS relate mainly to: (i) insufficient coverage and poor maintenance of health center; (ii) poor referral and counter-referral system between the three levels of the NHS; (iii) limited human resources and health technicians, in quality and quantity, and poor distribution of personnel in rural and peri-urban areas; (iv) weaknesses in the health management system, including the information, logistics and communications systems; (v) scarcity of financial resources and poor financing model; and (vi) limited access to safe drinking water, sanitation and energy.

The National Health System covers the National Health Service, which operates under the supervision and methodological guidance of the Ministry of Health, and is managed by provincial governors and municipal administrators. The following subsystems and supplementary services are part of the national system:

The **Health Service of the Angolan Armed Forces** – (DSS/EMG/FAA), which is the biggest national partner of the Ministry of Health with respect to assistance to communities in hard-to-reach areas, logistical support for large-scale campaign activities, and response to health emergency situations.

The **health education sub-system**, which covers technical and professional institutions as well as public and private medical schools.

**Health services of major parastatal companies** (SONANGOL, ENDIAMA and others).

The **National Civil Protection Service** (SNPC) of the Ministry of Interior, which takes the lead in organizing a response to natural disasters and emergencies, including public health emergencies. It is also responsible for health surveillance interventions organized by the National Police Force in areas relating to oversight, economic activities and border control.

**Profit-making and non-profit making private health services** (essentially run by religious institutions and NGOs).

## 2.9. Response of other sectors to health challenges

The response of other agencies of the Government of Angola to health challenges is basically governed by the 2012-2017 National Development Plan, implemented with the frameworks of the Poverty Eradication Programmes and Millennium Development Goals. The priorities of some key sectors are as follows:

**Agriculture:** The main concern of this sector is to achieve self-sufficiency in staple foods as well as food security, and to contribute to the development of local communities.

Ongoing interventions focus on: (i) developing competitive agriculture based on boosting small-scale production and reviving agribusiness; (ii) rehabilitating and expanding support infrastructure for agricultural and livestock production; (iii) using integrated strategies to stimulate associative and entrepreneurial practices; (iv) reviving cash crop production in order to generate profit and convert this activity into a traditional pillar of the national economy, with a view to boosting farmers' yields and national exports.

The key interventions in this area is the Veterinary Public Health Programme (pg. 92) which provides for (i) promoting tse-tse fly eradication; (ii) conducting contingency and emergency anti-rabies campaigns; (iii) implementing the project for containment of avian flu and other diseases, and (iv) ensuring control of the Newcastle disease, PPCB and dermatitis.

**Fisheries:** The objective is to promote the sustainable development of industrial and artisanal fishing, thereby contributing to job creation, with a view to combating hunger and poverty and guaranteeing food and nutritional security.

The sector priorities are to ensure a sustainable increase in production, combat illegal fishing in accordance with FAO recommendations, invest in fishery products conservation infrastructure and develop aquaculture.

**Energy and Water:** The following goals are expected to be attained by 2016: Create conditions for increasing per capita energy consumption eightfold; increase access for an estimated 2 million persons; and increase the share of renewable energy sources (wind + solar) in the entire energy matrix (set at 1.5%).

For the water sector, it is recommended that the national supply system be rehabilitated and expanded, with a view to attaining 100% coverage in urban areas and 80% in peri-urban and rural areas.

It is also recommended to increase the water supply in peri-urban and rural areas and conclude the “Water for All” programme, which is also intended to boost water distribution in peri-urban and rural areas.

**Trade:** The sector objective is to promote and maintain logistical infrastructure, trade circuits and a distribution network with a view to supplying the entire country with all essential consumer good and products.

**Environment:** The goal is to contribute to sustainable development, thereby ensuring environment protection and the quality of life of citizens. The main priorities include (i) mainstreaming the environment into economic and social development plans and programmes; (ii) developing a system for controlling environmental indicators; (iii) implementing national programmes on climate change; (iv) implementing environmental sanitation policies and ensuring good quality of life for citizens; (v) implementing strategies for managing national parks, integrated natural reserves and conservation areas; (vi) implementing and developing a national strategy for solid and urban waste management; (vii) promoting the use of clean energy and adopting green technologies, particularly in the oil, gas and petrochemical sectors.

**Occupational Health and Safety:** The Ministry of Public Administration, Labour and Social Security defined Occupational Health and Security as a fundamental pillar of public policies that benefit of workers, the economy and businesses.

Accordingly, the CSST (Centre for Occupational Health and Safety) was established as a public institution under the Ministry of Public Administration, Labour and Social Security, (MAPTSS). The CSST currently works with over 150 companies in various sectors, such as construction, oil and mining. Since its creation in 2010, it has evaluated more than 30,000 workers (Government Portal – [www.governo.gov.ao](http://www.governo.gov.ao)).

**Family affairs and women’s empowerment:** The main objectives are to foster family stability including: support for youths and protection for children and the aged; provision of differentiated social services to families and individuals, especially the most vulnerable; and promotion of equal opportunities, rights and responsibilities for men and women.

**Education, youth and sports:** The main objectives are to increase the literacy rate among women aged 15-24 years; raise the net primary enrolment ratio for children aged 6-11 years; increase the school attendance rate for children aged 6-17 years; and increase access to schools, particularly in rural areas. They also entail expanding the curriculum to include themes related to health, hygiene, environmental sanitation and nutrition, as well as the popularization of school sports by building appropriate facilities and providing trained coaches to stimulate an interest in sports.

**Social communication** plays a critical role in health promotion and in sensitizing different sectors of society to the fundamental importance of health as a factor of socio-economic development. Social communications media are a powerful and indispensable instrument for advocacy, social mobilization, health education, community participation, risk prevention, partnership consolidation and resource mobilization.

## 2.10. Contribution of the country to the global health agenda

Angola, as a member of the United Nations, has signed regional and global agreements on better health for the population and community development. Hence, its participation in the Global Health Agenda has been essentially geared towards attainment of the Millennium Development Goals.

The efforts made by the Government of Angola have facilitated the implementation of strategies to eradicate poliomyelitis. The country has

not recorded any case of polio since July 2011. Similarly, leprosy has been eliminated as a national public health problem since 2005, and there has been a reduction in the maternal, infant and child mortality rates. Furthermore, immunization has improved with a steady increase in coverage.

Assessment of Angola's performance in these areas has revealed the following best practices for reducing maternal and child mortality: the involvement of local authorities in immunization campaigns against measles and poliomyelitis, and in the administration of Vitamin A supplements; distribution of long-lasting insecticide-treated bed nets to pregnant women; promotion of institutional deliveries and antenatal visits; increased availability of intermittent preventive treatment (IPT); HIV/AIDS counselling and testing, family planning and ART for pregnant women; the basic food basket programme; the hand-washing campaign; community awareness-raising through information and educational materials to ensure participation in health campaigns on the promotion of exclusive breastfeeding from 0 to 6 months, and baby food from 6 months to 5 years; and the importance of administering vitamin A to children from the age of 6 months to 5 years. Another best practice is the free dissemination and support of all health initiatives by the media.

In a bid to improve maternal health and consequently reduce mortality rates, these best practices are geared towards developing the municipal health system. This initiative includes: better access to and improved quality of child care; the quality reproductive health; social mobilization to promote maternal and child health; monitoring and evaluation of services; and integrated interventions.

With regard to the attainment of MDG 6, the Government invested heavily in HIV, malaria and tuberculosis, and also in mobilizing the Angolan Armed Forces for public health activities, particularly HIV prevention through a successful country-wide prevention programme (UNDP, MDG Progress Report 2010).

## SECTION 3:

### COOPERATION AND DEVELOPMENT OF PARTNERSHIPS

The Government of Angola considers the development of multisectoral partnerships to be a critical strategy for facilitating and speeding up interventions aimed at improving the health status of its population. This strategy seeks to strengthen synergies with private profit-making and not-for-profit national and international health education institutions as well as grassroots organizations, United Nations agencies and other institutions that contribute to health development in the country.

These partners provide technical and financial support to the Angolan health sector. Their operations are consistent with the priorities defined in the 2013 – 2017 National Development Plan and the 2012–2025 National Health Development Plan (NHDP), which are the country’s main public policy implementation instruments during this period

#### 3.1. Analysis of interested parties

Development assistance increased from 238.71 million Kwanzas in 2009 to 242.35 million in 2012

**Table 5:** Global trends in development assistance to Angola (in millions of dollars)

	2009	2010	2011	2012
DA flows	238.71	238.23	194.25	242.35
Variation n+1/n em %	-1.24%	-0.41%	-18.48%	24,74%

Source: World Bank, 2014 (<http://databank.worldbank.org/>)

Various international partners cooperate with the country in many areas of development. However, the major health sector partners are: Cuban cooperation, the World Bank, the European Union, the Global Fund, USAID, PMI, JICA and United Nations agencies. In addition, there are active partnerships with NGOs; civil associations; local and foreign companies,

including oil companies; and regional organizations (SADC, CPLP, AU). The table below presents the main health sector partners for the 2009-2013 period. The European Union, World Bank and Global Fund support the programs of the Ministry of Health to strengthen the National Health System and implement the NHDP.

**Table 6:** Health sector partners in Angola, 2009-2013

Partners	Areas of intervention									
	EHA	EPI	HIV	MAL	TB	HSS	HRH	MPS	TRIP	HSD
USA			X	X		X				X
Italy										
Spain										
EC						X				
Sweden										
RU										
Norway										
Belgium										
Netherlands										
France										
Portugal						X	X	X		X
UNICEF		X								
UNFPA								X		
PSI										
China						X				
SC-RU										
World Bank						X				
GFTAM			X	X	X	X				
Oxfam										
MSF										
ABD										
Oil Companies						X				

Source: Office of International Relations, Ministry of Health, Republic of Angola, 2015

### 3.2. Coordination and Efficiency of Assistance to Angola

The leadership of the Ministry of Health within the sector is fundamental. There are coordination mechanisms at national level, namely: Interagency Coordination Committee (ICC) for the immunization programme and



the National Coordination Mechanism (NCM) for the Global Fund. These committees hold regular meetings and facilitate collaboration between different stakeholders in order to improve the implementation of their respective programmes.

Under the Harmonization for Health in Africa (HHA) initiative, WHO periodically convenes meetings of all health partners to foster collaboration and internal coordination of their actions in support of the Ministry of Health. Collaboration between WHO and CDC teams in Angola for training, monitoring and evaluation of the actions of public health professionals and rapid response to public health emergency teams continues to be a major asset.

### **3.3. Status of United Nations reforms and the UNDAF process**

The United Nations System in Angola provides assistance to the Government under a five-year cooperation agreement called UNDAF (United Nations Development Assistance Framework). The 2009-2013 UNDAF was extended till 31 December 2014 in order to align the next partnership framework with the Government's National Development Programme approved after the 2012 elections. For the next five-year period, the United Nations System has developed the new partnership framework called the United Nations Partnership Framework with the Government of Angola (UNPAF 2015-2019).

Within the UN system in Angola there are thematic coordination groups, of which WHO is an active member, namely: the UNCT (group of agency heads); the programme managers group; the disaster management team; and the monitoring and evaluation group.

There are also other programmes such as: the Joint Programme on Reproductive Health with the UNFPA, WHO and UNICEF; the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Joint FAO/WHO Programme on Zoonosis Control and Food Security.



## SECTION 4:

### REVIEW OF WHO COOPERATION IN THE LAST CCS CYCLE

The WHO cooperation strategy with the Government of Angola was reviewed through a consultative process involving all parties operating in the health sector. The process is in three stages, namely: (1) internal analysis (WHO) of results achieved, lessons learnt and difficulties encountered in the implementation of the strategy; (2) results analysis with the Ministry of Health; (3) consultation of the other health sector partners.

#### 4.1. Internal Evaluation

In the third quarter of 2013, the WHO team evaluated the progress made in the implementation of the cooperation strategy of the last five years (2009–2013). This evaluation was discussed with Ministry of Health authorities in October 2013, at a retreat of national directors, programme chiefs and heads of the technical departments in the Ministry of Health as well as the WHO technical team in Angola.

During the retreat, the results achieved, progress made, problems and constraints encountered, lessons learned and best practices were presented, as well as the degree to which implemented actions were consistent with national health policies and WHO global and regional guidelines.

#### **Key results achieved**

The key results achieved in the 2009 - 2013 period were as follows:

#### **Maternal and Child Health**

For the production of the strategic documents, WHO contributed to:

- Revision of the 2009-2015 Strategic Plan for the Reduction of Maternal and Child Mortality;
- Development of the 2012-2014 Reproductive Health Strategic Plan;

- Updating of the Roadmap for Accelerated Reduction of Maternal and Neonatal Mortality;
- Development of the technical standards for (1) management of obstetric and neonatal emergencies; (2) prevention and auditing of maternal and neonatal deaths; and (3) integrated management of antenatal consultation, delivery and care of neonates;
- Development of an integrated curriculum for in-service training in reproductive health;
- Development of an early childhood nutrition/feeding strategy and introducing the new WHO growth chart into the maternal and child health manual;
- Implementation of the initiative to improve pediatric care in reference hospitals.

## **Communicable disease control**

### **HIV/AIDS**

- Development of the National Plan for the Elimination of Mother-to-Child Transmission of HIV, 2012-2015;
- Updating of the 2010 and 2012 anti-retroviral therapy standards;
- Conduct of a survey in 2011 on the use of anti-retrovirals in Angola;
- Study on sero-prevalence in pregnant women in antenatal care, 2009 and 2011.

### **Malaria**

In terms of technical support, contributed to:WHO

- Drafting of the 2011-2015 National Malaria Strategic Plan;
- Drafting of the 2011-2015 National Malaria Surveillance, Monitoring and Evaluation Plan;

- Drafting of the technical manuals on: (1) management of malaria cases; (2) training of laboratory technicians; (3) integrated vector control; (4) training of technicians for the Malaria Early Warning System (MEWS).
- Establishment of MEWS in 4 southern provinces of Angola (Cunene, Huila, Kuando Kubango and Namibe), to prevent, detect and respond adequately to outbreaks.

## **Tuberculosis**

With regard to technical cooperation, WHO contributed to:

- Drafting of the 2008-2012 National Tuberculosis Control Strategic Plan;
- Revision and updating of the standards and procedures manual;
- Improvement of the programme information subsystem database;
- International external evaluation of the implementation of the 2008-2012 National Tuberculosis Control Strategic Plan;
- Drafting of the proposal for the 2nd Phase of the Global Fund Round 9 Tuberculosis Project.

## **Expanded Programme on Immunisation**

WHO provided intensive technical support to the central and provincial levels for:

- Interruption of wild poliovirus transmission, more than three years ago (the last case was reported on 7 July 2011);
- Increased routine immunization coverage (PENTAVALENT 3) from 81% in 2009 to 93% in 2013;
- Introduction of the Pneumo-13 vaccine into the Expanded Programme on Immunization;
- Planning, preparation, implementation and evaluation of 30 poliomyelitis immunization campaigns;

- Drafting of the 2011-2015 Comprehensive Multi-year Plan for EPI;
- Drafting of Emergency Plans for the Interruption of Wild Poliovirus Circulation in Angola for 2010, 2011 and 2012;
- Drafting of EPI Annual Operational Plans for 2009, 2010, 2011, 2012 and 2013;
- Preparation of the 2012-2015 Project for Introduction of the New Vaccines Pneumo-13 and Rotavirus and submission to GAVI;
- Drafting and updating of technical standards and instruments for immunization, surveillance, data management and logistics;
- Validation of the sentinel center for surveillance of pediatric bacterial meningitis (*Haemophilus influenzae* type b, streptococcus pneumonia) and rotavirus diarrhea;
- Creation and updating of databases right down to the municipal level and weekly monitoring of performance indicators.

## **Neglected tropical diseases (NTD)**

WHO provided technical assistance for:

- Attainment of the target of eliminating leprosy as a public health problem at the national level (less than one case per 10 000 population);
- Reduction of the incidence of human African trypanosomiasis by 49% over the last 5 years;
- Integrated mapping of onchocerciasis, loiasis, infant filariasis and dracunculiasis in 10 endemic provinces;
- Drafting of technical manuals and other normative instruments on (1) leprosy, (2) onchocerciasis and (3) human African trypanosomiasis.

## **Non-communicable diseases**

This programme was not sufficiently developed due to lack of human resources in the Ministry of Health. However, a case was made for it to be integrated into the 2012-2025 NHDP.

## **Epidemiological Surveillance, Emergency and Natural Disaster Management**

WHO technical cooperation contributed to:

- Investigation and response to outbreaks of cholera in 17 provinces; dengue fever epidemic in Luanda, Uíge and Kwanza-Sul; poliomyelitis in 10 of the 18 provinces (the last case was recorded in July 2011); measles all over the country; malaria in Cafunfo (Lunda Norte), Uige (sede) and Rivungo (Kuando Kubango); and anthrax in Huila;
- food poisoning in Huila province; a public health event of unknown cause (fainting spells) in schools in the provinces of Luanda, Cunene, Kwanzaa Sul, Cabinda, Uige, Benguela, Zaire, Kuanza Norte and Huila; droughts and floods in the south (Cunene) and other areas and districts of the country;
- Development and distribution of (weekly, quarterly and annual) epidemiological bulletins;
- Drafting of a National Capacity-Building Plan in compliance with the International Health Regulations;
- Revision and adaptation of International Health Regulation standards.

## **Health policies, Organization and Management of Health Systems**

WHO contributed to:

- Preparation of the bill on the National Health Policy, which was promulgated in 2010;
- Preparation of the bill setting up the National Commission for the Audit and Prevention of Maternal, Neonatal and Child Death;

- Drafting of the proposed 2012-2025 National Health Development Plan (NHDP);
- Drafting of the proposed national policy for grassroots interventions;
- Formulation of the National Pharmaceutical Policy, which has been approved and published;
- Drafting of the document on the Municipal Health System within the framework of decentralization;
- Drafting of the proposed “National Policy for Community Health Workers.

## **Human Resources: Strategic Management and Training**

WHO contributed to the:

- Conduct of the preliminary study on preparation of the Human Resources Development Policy and Plan for the Health Sector;
- Organization of a national forum for the formulation of the National Plan for the Development of Human Resources for Health in Angola;
- Drafting of the current Human Resources Development Policy and Plan for the Health Sector;
- Internal evaluation of training curricula for the Faculty of Medicine;
- Evaluation of middle-level training schools;
- Revival of training schools for health technicians, in accordance with the technical and vocational training reform.
- Acquisition and distribution of 24 municipal health libraries (Blue Trunk Libraries), for municipal level health professionals and nursing schools. Each library contains more than 180 books, documents and manuals.
- Creation of Human Resource Observatories in Huambo and Benguela provinces and establishment of databases human resources in health.



## **Health Information System and Research**

WHO provided technical support for:

- External evaluation of the Health Information System, in March 2010;
- Preparation of the Strategic Plan for the Health Information System.

## **Medicines and technologies**

WHO provided support for:

- Drafting/updating of the standard essential medicines list;
- Advocacy for the establishment of the Central Medical Store (CECOMA).

## **Health financing**

WHO provided support for:

- Advocacy for the administrative reform of government (concentration and decentralization) right down to the municipal level;
- Advocacy for the allocation of resources to primary health care at municipal level (60% of health resources);
- Preparation of projects to be funded by the Global Fund for tuberculosis (US\$ 4 million), malaria (US\$ 30 million) and HIV and AIDS (US\$ 80 million);
- Strengthening of the Municipal Health System with World Bank financing (US\$ 70 million);
- Strengthening of the health systems project with European Union financing (US\$ 25 million);
- Preparation of the project for the introduction of new vaccines: Pneumo-13 and Rotavirus, co-financed by GAVI (US\$ 55.9 million).

## Main constraints

The main identified constraints to technical cooperation were:

- The reduced number of WHO experts, which limits the technical support required for the development of priority programmes, with the exception of the Expanded Programme on Immunization, polio eradication and integrated disease surveillance that has an adequate technical team;
- Lack of clarity with respect to the role of WHO provincial offices, which creates difficulties for the implementation of activities in some provinces;
- Insufficient coordination in the preparation of some technical support missions, which ultimately undermines their efficiency;
- Poor coordination between the Ministry of Health and other ministries involved in health sector activities;
- Selection of national experts participating in international events sometimes done with little regard for the requisite expertise, and non-dissemination or follow-up of recommendations from said events.

## 4.2. External Review

The WHO cooperation strategy in the last cycle was also reviewed through a process that entailed consulting with stakeholders from the health sector and other sectors that contribute to national health development. This was done between June and August 2014. Most of the stakeholders recognized the important role and leadership of the WHO in managing public health globally, and in coordinating partners.

Partners from other ministries involved in health, the private sector, public-private partnership institutions, academic institutions and NGOs, identified the following difficulties in meeting sector needs:

- Poor performance by professionals graduating from the training institutes, due to insufficient practical training or poor work skills;

- Deficiencies in capacity-building and skills development, particularly among those who serve in remote areas; this makes it difficult to execute health strategies developed at central level;
- Discrepancies between some health sector and environment sector programmes on disease prevention and control;
- Shortcomings in the health information system, which consequently appears to be fragmented and uncoordinated;
- Insufficient WHO support to health research;
- Poor perception by NGOs and civil society organizations of WHO support for their activities;
- Weaknesses in the organization of health services at the most peripheral level and in health care provision by the referral and counter-referral system;
- Insufficient capacity of national institutions to prevent and treat chronic non communicable diseases (CNCDs);
- Insufficient specific interventions to build the technical capacity of nursing professionals and other auxiliary staff in health care delivery;
- Absence of a mechanism for coordinating NGOs and determining their degree of involvement and quality of work.



## SECTION 5:

### STRATEGIC AGENDA FOR WHO COOPERATION WITH ANGOLA

The proposed strategic agenda for WHO cooperation with the Republic of Angola for the 2015-2019 period is consistent with the current situation of the country, the results achieved and lessons learnt from the previous cooperation cycle and the WHO reform process. Furthermore, this agenda is consistent with the National Health Policy, the 2012-2025 Health Development Plan as well as the global and regional recommendations of WHO.

Accordingly, four strategic cooperation pillars for 2015-2019 were identified with the central team of MINSA namely: (i) health system strengthening; (2) improvement of maternal and child health; (3) communicable and noncommunicable disease control; and (4) preparation and response to epidemic outbreaks and emergencies.

#### **Strategic Agenda 1: Health system strengthening**

The development of a health system that is better structured, more efficient and equitable, with an expanded network of care and essential services that are functional and structured into referral levels, will facilitate the horizontal implementation of many priority programmes and projects.

In that regard, the WHO will focus its interventions on the following areas:

#### **Organization and management of health systems**

- 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.

## **Development of human resources**

- Finalization of the National Human Resources Policy and Strategic Plan, including dissemination and advocacy for implementation as well as the mobilization of partners;
- 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 centers 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.

## Health System strengthening and health research

WHO will focus its technical support on:

- Implementation of the Health Information System Strategic Plan (PESIS), including the integration of information on different health programmes and subsystems (public and private) and the definition and standardization of essential indicators for monitoring system performance from the operational to the central levels;
- Design of an integrated, simple, user-friendly health information system, at all levels, including support for the design and validation of recording instruments, consolidation, periodic reports and feedback, as well as the creation of an electronic platform for its computerized management;
- Technical capacity-building for GEPE professionals to ensure the management, update and adjustment of the information system, including the production and dissemination of standardized periodic reports and the organization of technical meetings, for the analysis and joint interpretation of information generated by the sub-systems;
- Establishment of a committee of experts to analyze, validate and publish health information;
- Development of a plan to monitor the general performance of health programmes, particularly public health programmes;
- Preparation of a draft Health Research Strategy and definition of a national research agenda;
- Preparation of a strategic plan and action plans for building national operational research capacity;
- Support for the establishment of ethics committees in institutions;
- Strengthening of the National Ethics Committee;
- 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.

## **Medicines, medical supplies and equipment**

WHO will focus its technical support on:

- Preparation of the national essential medicines and medical supplies list;
- Design and implementation of programmes for better planning and management of stocks and rational use of medicines and medical supplies;
- 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 of vaccines, medicines and supplies;
- 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.

## **Network of health laboratories**

WHO will focus its technical support on:

- Technical capacity-building for the laboratory staff of the National Public Health Institute (INSP) for international accreditation, and development of the national Network of Public Health Laboratories.
- Development and implementation of the National Health Laboratories Policy and establishment of the multisectoral committee of the national network of laboratories, as well as enhancement of the management and quality certification of regional reference laboratories;
- Revision and standardization of essential laboratory packages per level, as well as external and internal quality control;



- Standardization of the collection, packaging and transportation of samples of biological substances;
- Creation of a system for monitoring laboratory services;
- Expansion of the programme on Strengthening Laboratory Management towards Accreditation (SLMTA);
- Accreditation of laboratories for diagnosis of measles, yellow fever, HIV, malaria and tuberculosis.

### **Strategic Agenda 2: Improving maternal and child health**

WHO will focus its technical support on:

- Revision and updating of the National Reproductive Health Policy, adapted to the present context of national health system decentralization;
- Drafting of a National Child and Adolescent Health Policy, which covers all the services and care necessary for survival, growth and protection all through the life course;
- Development of the nutritional policy and strategy, including fortifying food with iodine, vitamins and mineral salts;
- Preparation of a strategic plan for youth and adolescent health;
- Revision and adaptation of integrated norms/standards and procedures for each level of care for women, neonates, children and youth/adolescents;
- Creation and institutionalization of center of excellence for capacity-building in health care services for women, neonates and children, in specialist, general and municipal hospitals;
- Strengthening and expansion of the referral and counter-referral system for emergency obstetric and neonatal care (basic and comprehensive) at the municipal level or for a group of municipalities;
- Strengthening the operationalization of committees for the prevention and audit of maternal, neonatal and child deaths, integrated into epidemiological surveillance and response;

- Scaling up training on the control of child growth and development and IMCI in permanent training centers and training schools for health technicians, including essential care for neonates, kangaroo-mother care services and malnutrition management;
- Technical support for the introduction of management tools (ICATT/IMCI);
- Development of comprehensive communication and advocacy plans on women's and children's health, with emphasis on repositioning of family planning (FP);
- Support to the mainstreaming of women's health interventions, including family planning, nutrition, malaria, STD, HIV and AIDS;
- Support for gender mainstreaming and integration of reproductive rights into women's health care within the health services network;
- Evaluation of the implementation of women's and child health programmes, including community IMCI implemented by NGOs in some provinces;
- Support for the development of advocacy, communication and social mobilization, based on operational research in the country's different socio-cultural contexts.

## **Strategic Agenda 3: Disease Control**

### Communicable diseases

WHO will provide technical support for the:

- Drafting/updating of national policies, strategic plans and standards on HIV/AIDS, tuberculosis, malaria, vaccine preventable diseases, neglected tropical diseases and others;
- Dissemination of innovative strategies and methodologies for the prevention and control of priority, emerging and re-emerging communicable diseases;
- Development, monitoring and evaluation of strategic plans for the procurement, quality control, distribution and proper use of medicines,

vaccines, and other biological products used in the prevention, diagnosis and control of priority diseases;

- Guidance of the Regulatory Authority for medicines, vaccines and products to ensure the implementation of established standards and regulations;
- National capacity-building for operational research, supervision and evaluation for decision-making;
- Strengthening and expansion of integrated surveillance at sentinel sites for HIV/AIDS and malaria;
- Study of anti-retroviral (ARV) resistance, multidrug-resistant tuberculosis (MDR-TB) and the efficiency of current anti-malaria drugs;
- Preparation of the National Immunization Policy under the NHDP;
- Provision of guides, teaching materials and updated standards to improve the quality of vaccination services, safe injections, cold chains and safe introduction of new vaccines;
- Preparation of strategic plans for the elimination of measles and neonatal tetanus, expansion and maintenance of cold chains to preserve vaccines;
- International external evaluation of the Expanded Programme on Immunization and development of the 2015-2025 Integrated Multiyear Plan;
- Technical assistance to attain and maintain levels of excellence for vaccine-preventable disease surveillance, with emphasis on sentinel surveillance for bacterial meningitis, rotavirus diarrhea and side-effects of immunization;
- Development of contingency plans for poliovirus and a strategic plan to speed up poliomyelitis eradication in Angola;
- Strengthening of the coordination and integrated implementation of cross border activities for vaccine-preventable diseases and other priority diseases;

- National capacity-building for the update of instruments and technologies for prevention, early screening, diagnosis and treatment of communicable diseases;
- Strengthening of national and international partnerships for the mobilization of funds at the national level and the quest for new technologies;
- Implementation of capacity-building for communicable diseases control at community level;
- Regular updating of the communicable disease mapping, with emphasis on neglected tropical diseases;
- Organization, coordination, monitoring and evaluation of the emergency intervention plan of the 2015-2016 leprosy programme.

## **Non-communicable diseases**

- Development, monitoring and evaluation of the National strategic plan for the control and prevention of noncommunicable 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, with a view to reducing the causes/determinants of communicable and non-communicable diseases.

## **Strategic Agenda 4: Preparation, surveillance and response to epidemic outbreaks and emergencies**

WHO will provide technical support for:

- Updating of the strategic plan for integrated disease surveillance and response (IDSR) and expansion of the strategy to all municipalities, while including information from vertical programmes and community participation (community-based surveillance);
- Implementation of the IDSR human resource plan, particularly the creation of a critical mass of employees trained in epidemiological surveillance and data management at the municipal level, and who are able to use new technologies;
- Continuation of capacity-building as required by International Health Regulation (IHR 2005), especially for surveillance at entry points and annual evaluation of the implementation of IHR recommendations;
- Development of epidemic and disaster risk management policies and strategies, and national capacity-building for appropriate risk management;
- 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;
- Technical support to national capacity-building for the implementation and evaluation of environmental surveillance of etiological agents of disease, particularly poliovirus; development of a communication strategy based on operational research, to improve mass media and interpersonal communications strategies.



## SECTION 6:

### IMPLEMENTATION OF THE STRATEGIC AGENDA: IMPLICATIONS FOR WHO

Angola is continuing its national reconstruction process through socioeconomic development and institution-building. Accordingly, the Ministry of Health has undertaken to implement health sector reform based on the improvement of management at the central, provincial and municipal levels, as well as decentralization of the health system.

Technical and managerial capacity-building for provincial and municipal services is crucial to the success of the reform process. The country is still experiencing a quantitative and qualitative shortage of human resources in health.

Consequently, with regard to country assistance under CCS 2015-2019, and taking account of the recommendations made by various health sector stakeholders as well as the 6 core functions of the Organization, the WHO technical team has defined its role and underscored the relevance of its presence in the country.

#### **6.1. Role and presence of the WHO in the country**

In accordance with its core functions, WHO will provide the country with technical assistance at the central and local levels to strengthen its institutions, prevent and control communicable and noncommunicable diseases, promote health, develop human resources and build research and information systems, in order to improve access to quality health care, achieve greater health benefits and contribute to the attainment of the health targets of the post-2015 Agenda.

The government and health sector partners recognize the technical leadership role of the WHO in Angola. The Organization is present at national level and in all 18 provinces, focusing on integrated disease surveillance in general and on vaccine-preventable diseases in particular. Over the last five years,

the work of the WHO provincial teams has been expanded to support other priority programmes of the Ministry of Health under NHDP implementation.

In order to ensure implementation of the WHO cooperation programme with Angola, there is need to:

- Strengthen the WHO team: At the central level, qualified technicians are needed to support the Research, Planning and Statistics Unit of the Ministry of Health, the National Department of Human Resources and the National Public Health institute;
- Provide occasional technical assistance to the National Accreditation Institute, particularly for health training institutions;
- Support resource mobilization for various priority and cross-cutting interventions such as maternal and child health, neglected tropical diseases, HIV, malaria, TB, vaccine-preventable diseases, health promotion and health system development.

## **6.2. Monitoring and evaluation of the Cooperation Strategy**

The CCS is implemented through biennial work plans. Accordingly, the current CCS will be subject to a biennial work plan monitoring and evaluation mechanism. The main monitoring and evaluation stages are:

Weekly work plan monitoring meetings to determine the status of implementation of planned activities and make adjustments as appropriate.

Mid-term evaluation of the strategy (3rd year), to determine the status of implementation of planned activities, reprogramme actions and redefine cooperation strategies for the coming year. The results obtained will be presented to the Ministry of Health and all interested parties, including technical and financial partners.

Final evaluation at the end of the cooperation cycle, to determine progress made, analyze lessons learned and define priorities and mechanisms for effective follow-up of the objectives of the next cooperation cycle 2020 -2024.

The objective of the WHO cooperation strategy with the Government of Angola for 2015-2019 is to consolidate and build on the gains of the previous



period, focusing on four priority pillars: (1) health system; (2) improvement of women's and children's health; (3) communicable and noncommunicable disease control; and (4) preparation and response to epidemic outbreaks and emergencies.

The effective implementation of this strategy will depend on the availability of adequate human and financial resources and better coordination of partners.

## **Annexes**

Basic Indicators for Angola



## Annex 1: Basic Indicators for Angola

Indicators	Year	Units	Level
<b>Demographic and socioeconomic statistics</b>			
Population (figures)*	2014	n	24383301
Population (annual growth rate) **	2013	%	1,5%
Surface area *	NA	Km2	1246700
Population density *	2014	n/Km2	19
Population aged 15 years **	2013	%	47.4
Urban Population *	2014	%	62.3
Total fertility rate (per woman) **	2012	%	5.98
Primary school attendance rate (boys)**	2010	%	93.1
Primary school attendance rate (girls)**	2010	%	78.2
Adult literacy rate**	2013	%	70.4
Gross national product <i>per capita</i> **	2013	USD	6770
Population living below the poverty line**	2009	USD	43.47
<b>Health status - mortality statistics</b>			
Life expectancy at birth (years) **	2012	Both sexes	51
Under-five mortality rate (per 1000 live births) **	2013	Both sexes	167
Infant mortality rate (per 1000 live births) **	2013	Both sexes	102
Neonatal mortality rate (per 1000 live births) ** **	2013	Both sexes	47
Maternal mortality rate (per 100 000 live births) **	2013	Female	460
HIV prevalence among adults (15-49) **	2013	Both sexes	2.4
Tuberculosis prevalence (per 100 000 inhabitants)	2013	Both sexes	423

Incidence of tuberculosis (per 100 000 inhabitants) **	2013	Both sexes	320
Number of confirmed cases of poliomyelitis **	2013	Both sexes	0
<b>Behaviour and environmental risk factors</b>			
Population having access to sanitation **	2012	%	60
Population having access to an improved water supply source**	2012	%	54
<b>Health services coverage</b>			
Measles vaccination for infants (less than 1 year) **	2013	%	91
DTP3 **	2013	%	83
Antiretroviral therapy coverage **	2013	%	26
TB detection rate using DOTS **	2013	%	85
Successful TB treatment rate, using DOTS **	2012	%	45
<b>Health system statistics</b>			
Total health expenditure (as % of GDP) **	2014	%	2.70
General government expenditure on health (as % of total health expenditure) **	2012	%	62.2
Private health expenditure (as % of total health expenditure)**	2012	%	37.8
Public health expenditure (as % of total public expenditure)**	2012	%	5.6
Doctors (per 1000 inhabitants) **	2012	N per 1000 inhabitants	0.166
Nurses (per 1000 inhabitants) **	2012	N por 1000 inhabitants	1.66

Source: \*Censo, Angola, 2014 \*\*; World Health Organization. Global Health Observatory 2015 (<http://www.who.int/gho/en/>)