

UNDERSTANDING ANGOLA'S HEALTH & NUTRITION SECTORS

A PUBLIC EXPENDITURE REVIEW | 2023

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Thank you.



Abbreviations

ADRA	Action for Rural Development and Environment initiative <i>Acção para o Desenvolvimento Rural e Ambiente</i>
BCG	Bacillus Calmette–Guérin (Vaccine)
CGE	General State Account <i>Conta Geral do Estado</i>
CSPR	Center of Security of the President of the Republic <i>Casa de Segurança do Presidente da República</i>
DALYs	Disability-adjusted Life Years
DHIS2	Digital Health Information System 2
DRC	Democratic Republic of the Congo
DTP	Diphtheria, Pertussis (Whooping Cough), and Tetanus (Vaccine)
EC	European Commission
FAO	Food and Agriculture Organization of the United Nations
GDP	Gross Domestic Product
GEPE	Office of Studies, Planning and Statistics <i>Gabinete de Estudos e Planeamento de Estatísticas</i>
HBV	Hepatitis B Virus
HepB3	Hepatitis B (Vaccine) 3 rd Dose
Hib3	<i>Haemophilus influenzae</i> B (Vaccine) 3 rd Dose
HPV	<i>Human Papiloma Virus</i>
MASFAMU	Ministry of Social Care, Family and Women's Promotion <i>Ministério da Acção Social, Família e Promoção da Mulher</i>
MDT	(Leprosy) Multidrug Treatment
MESCTI	Ministry of Higher Education, Science, Technology and Innovation <i>Ministério do Ensino Superior, Ciência, Tecnologia e Inovação</i>
MINAGRIF	Ministry of Agriculture and Forestry <i>Ministério da Agricultura e Florestas</i>
MINDENVP	Ministry of National Defense and Veterans <i>Ministério da Defesa Nacional e Veteranos da Pátria</i>

MINIT	Ministry of the Interior <i>Ministério do Interior</i>
MINOPOT	Ministry of Public Works and Spatial Planning <i>Ministério das Obras Públicas e Ordenamento do Território</i>
MINSAs	Ministry of Health <i>Ministério da Saúde</i>
NHS	National Health System
OGE	General State Budget <i>Orçamento Geral do Estado</i>
OPV	Oral Polio Vaccine
PDN	National Development Plan <i>Plano de Desenvolvimento Nacional</i>
PER	Public Expenditure Review
PPE	Personal Protective Equipment
SINAS	National System for Health Performance Evaluation <i>Sistema Nacional de Avaliação em Saúde</i>
SUN	Scaling-Up Nutrition
TB	Tuberculosis
UHC	Universal Health Care
UNDP	United Nations Development Program
UNICEF	United Nation's International Children's Emergency Fund
VAS	Vitamin A Supplementation
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization of the United Nations

Executive Summary

Angola's health and nutrition sectors have made enormous progress since the beginning of the century. For example, between 2012 and 2022 alone, the country lowered its maternal mortality ratio by 29%. Neonatal, infant and under-five mortality rates have also decreased by 30%, 19% and 28% respectively, between 2012 and 2020.

Such progress has been accompanied by an increase in the complexity of financial reporting on the sector by the Government. The General State Budgets and Whole of Government Accounts have become increasingly more transparent and detailed — which in turn allows for the analysis of the performance of Public Expenditure.

This report provides a Public Expenditure Review (PER) of the Health and Nutrition sectors in Angola, identifies key challenges and provides a way forward to address the challenges that remain.

The annual health budget in Angola steadily increased between 2016 and 2022 — showing a 299% growth, as it averaged 5.0% of the General State Budget. However, the nominal growth does not necessarily reflect an actual increase in investment for the sector when accounting for inflation. This is further aggravated by relatively low execution rates — which averaged 75.6% between 2012 and 2021.

In 2022, the health budget represented 4.8% of the OGE and 1.6% of the Gross Domestic Product, amounting to a total of Kz 905.5 billion (US\$ 2.6 billion) or Kz 27.3 thousand per capita (US\$ 54 per capita). The budget is heavily centralized in the Central Government, with only 38% of the budget going towards the Provincial Governments in 2022. And General Hospital Services and Public Health Services are by far its two largest components of the health budget — having a combined representation of over 60% since 2013.

Total health expenditure in Angola is low overall, especially considering its growing population. It is heavily funded by Domestic Government Expenditure, but the largest source of financing is Domestic Private Expenditure, mostly Out-of-Pocket Expenses — which puts an enormous financial burden on households. In terms of Total Health Expenditure as a percentage of GDP, Angola ranks 45th out of 47 African nations.

Regarding the focus on nutrition, the work presented here is one of few reports which specifically targets the sector. The poor nutritional status of a large portion of the Angolan population makes the topic tremendously important, especially considering that malnutrition is one of the leading risk factors for attributable disability-adjusted life years in the country.

Historically, Angola's nutrition budget has been steadily increasing. In 2022, it was Kz 529.0 billion (US\$ 1.1 billion) — which represented 2.8% of the OGE and Kz 16.0 thousand per capita (US\$ 34.7 per capita). Nutrition-specific interventions comprised 1.6% of the budget, while nutrition-sensitive interventions represented 97.8%. This is a ratio of specific-to-sensitive of 1.7% (1/60). As per nutrition-enabling interventions, they covered the remaining 0.5% of the budget.

A thorough analysis of the various health services and programs has provided key insights into the sector's public expenditure. Most noticeably, there is a severe inconsistency between health and nutrition policy documents. This is particularly striking for those focusing on nutrition. Furthermore, health and nutrition policies are more accurately reflected in the General State Budget when included in Nacional Development Plan 2018—2022, as opposed to the National Sanitary Development Plan 2012 – 2025.

Angola also struggles with routine surveillance of the health status of its citizens, which in turn has made it impossible to implement a results-based budgeting strategy. This is further aggravated by evidence that, when data is available, the budget does not necessarily adapt to the information- For example, targets are defined with long-term objectives in mind and are not adjusted based on the results of the previous years on an annual basis.

Finally, it has also become clear that routine immunization needs greater funding. According to the WHO, in 2021, the Government of Angola spent US\$ 28.7 million (Kz18.3 billion) on routine immunization — the equivalent US\$ 28.9 per surviving infant (Kz 18.4 thousand) that year. For comparison, the WHO African region spent on average, between 2018 and 2020, US\$ 41 per surviving infant.

According to government data provided to the WHO, for the past ten years, general immunization coverage in Angola either follows or is above the average estimated coverage for the WHO African region. However, official reporting is in most cases above the estimated coverage calculated by WHO and UNICEF. If we consider the WHO/ UNICEF estimates, coverage in Angola is typically below average by roughly 20 p.p.

Based on the key conclusions of the Public Expenditure Review, we present in the following report 8 recommendations:

1. Continue to increase the annual health budget

Angola has a long way to go to achieve universal health coverage and for that it requires a greater financial commitment on behalf of its Government. In order to achieve the commitment made in the Abuja Declaration of 2021 to allocate 15% of the OGE towards the health sector, the Government would need to increase the health budget by 42% annually until 2027 or by 30% annually until 2030.

2. Establish an operational multisectoral body to coordinate the National Food and Nutrition Security Strategy

The governance of the nutrition sector is fragmented between MINSA and MINAGRIF. Although a Nacional Multisectoral Platform for Nutrition was established in 2018; we were not able to determine whether or not the platform is active. The Government should seek to reactivate this platform and/or to provide the means to make this multisectoral body more operational.

3. Ensure Predictability of the Development Budgets to Nurture Long-term Strategies

Each program should have a medium to long-term investment plan — adjacent to the National Development Plan. This would ensure that those coordinating the programs would be able to plan and implement long-term projects. Additionally, the fact that budget is allocated on a monthly basis prevents adequate resource mobilization, namely because public contracting procedures tend to require long periods of time.

4. Restructure and align nutrition indicators according to international recommendations

We propose that Angola adopt the four indicators and respective targets defined in the WHO Global Nutrition Targets 2025 and the WHO/UNICEF extension of the target to 2030, within the scope of the Program for the Improvement of Maternal and Child Health and Nutrition.

5. Create a National System for Health Performance Evaluation

Establish a National System for Health Performance Evaluation (SINAS, *Sistema Nacional de Avaliação em Saúde*) responsible for monitoring hospital and health centers performance, that will serve as a basis for further involvement of local health facilities in decision-making and budgeting strategy.

6. Actively Invest and engage in Health Monitoring

It is important for the Government to restart nation-wide surveys but also to increase their frequency. There should also be an increase in funding for the program for the Strengthening of the Health Information System and Development of Health Research — which is responsible for the implementation of the Epidemic Outbreak Reporting System and the Digital Health Information System (DHIS2).

7. Continue to Improve National Budget Accountability and Detail

State Budgets and Whole of Government Accounts have become increasingly more detailed and informative. This is a welcome effort which needs to be continuously improved upon. In this report we provide a short list of further improvements that can be made in the future.

8. Increase Expenditure on Routine Vaccination and Perform a Financial Analysis on Cost-Effectiveness

Routine immunization not only reduces child mortality, but it is also a sound long-term investment plan. The government should therefore consider an increase in spending on routine vaccination guided by a National Strategy to Strengthen Routine Immunization, as well as perform a financial analysis on cost-effectiveness in order to maximize future funding.

All these recommendations aim to support the commitments recently made by the Government of Angola in the Luanda Declaration (2022)¹.

¹ WHO, [Reforçar os cuidados de saúde primários em Angola](#) (2022)

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1. Background

1.1. Context and Objectives

The main objective of this Public Expenditure Review (PER) of the Health and Nutrition sectors in Angola is to assess the size, composition, equity, and efficiency of spending in relation to sector performance. Health and nutrition are two areas which are intrinsically connected to one another. Here, we will review the basic structure of the country's health system and analyze how government funds are allocated within the health and nutrition sectors, budgeting equity and general efficiency. The analysis aims to provide a tool to further improve the budget allocation of the Government of Angola, as well as a mechanism by which stakeholders within the sector can better understand national healthcare expenditure.

The last PER to focus on the health sector in Angola was published in 2007². It was a joint product developed by the World Bank in collaboration with a group of multiple development partners of the Government of Angola, including the European Commission (EC), the Food and Agriculture Organization of the United Nations (FAO), the World Health Organization (WHO), the United Nations Development Program (UNDP), and the United Nations Children's Fund (UNICEF). And it provided a broad and extensive analysis of the sector in the country and the structure of expenditures in health.

This analysis concluded with an extended list of 18 detailed recommendations on how to improve public spending in health. These recommendations focused on the following five key issues:

1. The need to increase public spending on health and nutrition;
2. The need to review budget categories;
3. The need to establish a Results-based Budgeting System, with monitoring mechanisms and performance indicators;
4. The need for a Strategic Investment Plan in health and to increase strategic planning capacity;
5. The need to increase decentralization in the basic healthcare network.

The current review intends to update the findings of the previous report, published sixteen years ago, and further build upon them by reassessing the key issues highlighted and by extending the analysis scope — including an in-depth look

² World Bank, European Commission, Food and Agriculture Organization, United Nations Children's Fund, United Nations Development Program, World Health Organization (2007). [Angola: Public Expenditure Review, Volume 1. Policy Briefing](#) and [Volume 2. Sectoral Review](#).

at how expenditure in nutrition is budgeted. Furthermore, this document, which will cover the last decade (2012 — 2022) and focus particularly on the period between 2018 and 2022, will distinguish itself by its focus on the impacts of the overall public expenditure on children, their health and quality of life — especially in the last five years.

Regarding the focus on nutrition, the work presented here is one of few reports which specifically targets the sector. Nutritional Public Expenditure Reviews are a relatively new endeavor, with only 7 reviews published to date (Bangladesh, Bhutan, Indonesia, Nepal, Rwanda, Sri Lanka and Tanzania) — the oldest one published in 2018. This report, which was developed considering the guidelines established by the World Bank³, will hopefully build upon a living body of work that will serve as the basis for better budgeting around nutrition.

Like in the previous review of 2007, the current study — its scope and analysis — is limited by the availability of data in Angola, but also by the information made available to the team during the development of this project, both by the Government of Angola and the non-governmental organizations which collaborated in it.

1.2. Policies and Governance of the Health and Nutrition Sectors

1.2.1. Health: Policies

To understand public expenditure in the health sector in Angola, it is essential to first comprehend the links between each of the stakeholders, how they interact with one another and the policy frameworks that structure the sector.

In 2011, the Government of Angola created — through Presidential Decree n° 84/11, of October 27th — a multisectoral committee, coordinated by the Minister of Health, which was in charge of drafting the **National Sanitary Development Plan 2012 – 2025**⁴ (*Plano Nacional de Desenvolvimento Sanitário 2012-2025*), published in 2015. This document is considered one of the sector’s core policy tools, designed to support the National Health System technically, financially and politically. It is both a strategic and operational document, pushing forward both **Long-Term Development Strategy for 2025** (Angola 2025), published in January of 2007⁵, and the **National Health Policy** (*Política Nacional de Saúde*), highlighting governmental priorities as well as proposing concrete actions and interventions.

³ World Bank, [A Guiding Framework for Nutrition Public Expenditure Reviews](#) (2022).

⁴ [Plano Nacional de Desenvolvimento Sanitário 2012 – 2025](#)

⁵ [Angola 2025: Angola um País com Futuro](#) (2007)

Its drafting was a participated process, involving the National Health Programs, several Provinces, national and international partners, taking into account a literature review of key documents, such as the above-mentioned Long-Term Development Strategy: Angola 2025 and the National Health Policy, as well as the most recent available data on the health status of the population.

There was significant contribution from the 9 Health Programs implemented at the time:

1. Prevention and Fight Against Disease
2. Provision of Primary Care and Hospital Assistance
3. Management and Human Resources Development
4. Health Research Development
5. Management and Development of the Health Network
6. Management and Development of the Supply and Logistics of the Health Sector, and development of the Pharmaceutical Sector and Management of Medical Devices
7. Reinforcement of the Sanitary Information System and Development in Health Research
8. Development of the Institutional Health Sector
9. Financing and Financial Sustainability of the National Health System

The latest **National Development Plan 2018 - 2025** highlights the continued commitment of the Government to “fight poverty and promote the sustainable improvement of the health status of the Angolan people, supporting in particular the most vulnerable and poor population groups, ensuring a healthier longevity”. In it, the National Public Health Plan 2012 - 2025 is once again mentioned as the key strategic document. However, the Health Programs in place have changed. There are now four health Programs with specific objectives and measurable outcomes:

1. Improvement of Medical and Medication Assistance
2. Improvement of Maternal and Child Health and Nutrition
3. Fight Against Major Endemic Diseases Through Health Determinants Approach
4. Reinforcement of the Sanitary Information System and Development in Health Research

1.2.2. Health: Governance

There are different levels of Governance within the Health Sector in Angola:

The top level includes the **Ministry of Health** (MINSA; *Ministério da Saúde*) and other national Institutions. MINSA is responsible for i) defining the sector's policies, ii)

preparing, monitoring and evaluating strategic plans for the sector and iii) regulating the sector.

Within the structure of the Ministry of Health there are several Directorates, Departments and Cabinets⁶. (National Public Health Directorate, National Human Resources Directorates and National Directorate of Hospital Care, General Secretariat, IT and Communication Cabinet, Legal Cabinet, Exchange Cabinet, Planning and Statistics Cabinet, Ethics and Humanization Cabinet and the "*Junta Nacional de Saúde*").

MINSa delegates the role to provide policy definition, strategic planning, monitoring and oversight of province level health service delivery to National Public Health Directorate National and the Directorate of Hospital Care and, additionally, to the National Institute for Fight of HIV/AIDS.

The National Public Health Directorate is currently composed of three departments — Dept. of Primary Healthcare, Dept. of Hygiene and Epidemiological Surveillance and the Dept. of Disease Control. Each of these entities, in turn, has a subset of National Programs, focusing on particular topics within health and nutrition.

At the provincial level, the **Provincial Cabinets of Health** are the ones responsible for the tactical and operational implementation of the health policy. And at the local level, the **Municipal Health Departments** implement the operations according to the policies in place. There are significant differences between allocated resources through the different levels, as well as between different organizations at the same level — as will be described in Chapter 2.2.

Provision of care and health services delivery is also organized through a three-tiered system: primary level (community health centers, sanitary posts and municipal hospitals), secondary level (provincial hospitals and maternities) and tertiary level (specialized hospitals).

Provincial governments are responsible for their province's healthcare network, including the primary and secondary levels. Despite Provincial Hospitals being under the tutelage of the Provincial Governments they enjoy a certain degree of operational autonomy. Regarding the tertiary level, there has been a significant development over these last years. It is important to note that both MINSa and the Provincial Governments have hospitals under their tutelage.

There are also five subsystems and supplementary services considered part of the national system⁷:

⁶ [Ministério da Saúde de Angola](#)

⁷ WHO, [Country Cooperation Strategy: At a Glance](#)

- The Health Service of the Angolan Armed Forces (DSS/EMG/FAA), which is the biggest national partner of MINSa with respect to assistance to communities' services of major public companies (SONANGOL, ENDIAMA and others);
- The National Civil Protection Service 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 private parties in hard-to-reach areas that provide 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 and non-profit making private health services, essentially run by religious institutions and non-governmental organizations.

1.2.3. Nutrition: Policies

The poor nutritional status of a large portion of the Angolan population has been recognized as a challenge in various national strategic documents. A subject which has gained increasing relevance over the years and whose policies have grown in complexity. The following is a list of the most relevant Angolan policies in the field of nutrition in a chronological order:

1. Poor nutritional status was recognized as a weakness for the national development of the country in the **Long-Term Development Strategy for 2025** (Angola 2025), published in January of 2007⁸. In this document, it is mentioned that, in 2004, there was a nutrition program which focused on nutritional surveys in some provinces, vitamin A supplementation and salt iodization.
2. The **National Food and Nutrition Security Strategy**⁹ (2009 – 2013) was launched in 2009 through an inter-ministerial effort coordinated by the Ministry of Agriculture. Its objectives include decreasing the levels of malnutrition by improving food access, primary healthcare services, education and sanitation, and the creation of an intersectoral platform for coordinating policies and actions on food and nutrition security, with civil society participation. A joint report by UNICEF and the Action for Rural Development and Environment initiative (ADRA; *Acção para o Desenvolvimento Rural e*

⁸ [Angola 2025: Angola um País com Futuro](#) (2007)

⁹ [Estratégia Nacional de Segurança Alimentar e Nutricional](#) (2009)

Ambiente) in 2018 revealed that the National Food and Nutrition Security Strategy had not yet been effectively implemented¹⁰.

3. In the **National Development Plan 2013 – 2017**¹¹ (PDN; *Programa de Desenvolvimento Nacional*) published in 2012, the Government defined several key programs and measures for the health sector. One of the recommended *measures* within the program of “provision of healthcare” pertained to nutrition and consisted on the “prevention and treatment of nutrition disorders”. This measure had only one performance indicator: vitamin A supplementation coverage rate in children aged 6 – 59 months, whose target was to achieve 95% coverage by 2017.
4. In 2015, the **National Sanitary Development Plan 2012 – 2025**¹² was launched, including a project on the “prevention and treatment of nutrition disorders” with, among others, the following six targets:
 - i. Reduce prevalence of under-five stunting to less than 5%, until 2021
 - ii. Increase proportion of exclusive breastfeeding in the first 6 months to 85%, until 2021
 - iii. Increase coverage of vitamin A supplementation in children aged 6 – 59 months to 95%, until 2021
 - iv. Reduce prevalence of under-five underweight to less than 10%, until 2021
 - v. Increase coverage of household consumption of iodized salt to 90%, until 2021
 - vi. Increase coverage of antenatal iron and folic acid supplementation to 95%, until 2025
5. The latest Angolan policy document that defines national targets in the field of nutrition to which we had access is the **PDN 2018 – 2022**¹³ issued in 2018. It encompasses a program on “improving maternal and child health and nutrition”. One of the program’s objectives is to improve the nutritional status of children under 5 years of age through micronutrient supplementation with the following three targets:
 - i) Reduce prevalence of under-five malnutrition from 19% in 2016 to 9% in 2022
 - ii) Increase proportion of exclusive breastfeeding in the first 6 months to 80%, until 2022
 - iii) Increase coverage of vitamin A supplementation in children aged 6 – 59 months to 60%, until 2022

¹⁰ ADRA, UNICEF, [Nutrição, segurança alimentar e agricultura no Orçamento Geral do Estado 2018](#) (2018)

¹¹ [Plano de Desenvolvimento Nacional 2013 - 2017](#)

¹² [Plano Nacional de Desenvolvimento Sanitário 2012 – 2025](#)

¹³ [Plano de Desenvolvimento Nacional 2018 - 2022](#)

In the first target it is not clear which form of malnutrition is concerned. Considering the data reported in Angola's National Demographic and Health Survey (IIMS; *Inquérito de Indicadores Múltiplos e de Saúde*) 2015 — 2016¹⁴, we can deduce that it is related to the percentage of underweight children.

Concluding our review on relevant Angolan policies in the field of nutrition, it is important to highlight that there are two known policy documents to which the analytic team could not access, and therefore could not analyze. Namely, the National Nutrition Strategy for Early Childhood, and the National Food and Nutrition Policy. Additionally, the Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition National Integrated Strategy is currently being elaborated.

1.2.4. Nutrition: Governance

Regarding governance, the nutrition sector in Angola is fragmented, with relevant functions integrated in different ministries.

The National Nutrition Program (*Programa Nacional de Nutrição*) is one of the programs within the Department of Primary Healthcare of the National Public Health Directorate. Therefore, it is under the tutelage of MINSA. It focuses on capacity building of the primary health care providers regarding development of protocols for diagnosis and treatment of acute malnutrition and treatment, on the monitoring of nutritional health and on strengthening cooperation between regional and national health authorities. For example, the program is behind the development and implementation of the Protocol for the Integrated Management of Acute Malnutrition¹⁵. It is the entity largely focused on the policies regarding nutrition-specific interventions.

The National Department for Food Safety, on the other hand, is inserted within Ministry of Agriculture and Forestry (MINAGRIF). Its role is mainly on the regulation and monitoring of food security and quality systems within Angola. MINAGRIF is currently responsible for the development of the National Food Quality System and the Information and Alarm System for Food and Nutritional Security (*Sistema de Informação e Alerta Rápido para a Segurança Alimentar e Nutricional*).

The Ministry of Social Care, Family and Women's Promotion (MASFAMU; *Ministério da Acção Social, Família e Promoção da Mulher*) is largely responsible for leading social care initiatives and providing social aid to the most impoverished. Their work often includes providing food assistance to families, thus preventing undernutrition in children. The Ministry is therefore deeply connected to the nutrition sector, albeit in an indirect way.

¹⁴ Inquérito dos Indicadores Múltiplos de Saúde (IIMS; 2016).

¹⁵ *Protocolo de Gestão Integrada da Desnutrição Aguda* (GIDA; 2019)

Finally, there is a National Multisectoral Platform for Nutrition (*Plataforma Multisectorial Angolana para a Nutrição*), launched in 2018, which sought to offer a space for intersectoral coordination on the nutrition sector¹⁶. Over the course of our study, we were unable to determine whether or not this platform is active, who integrates the platform nor what initiatives are being implemented under the platform's work.

¹⁶ ADRA, UNICEF, [Nutrição, segurança alimentar e agricultura no Orçamento Geral do Estado 2018](#) (2018)

2. Health and Nutrition Sector's Performance

2.1. The Current Status of Health and Nutrition in Angola

Angola is a lower-middle income Sub-Saharan African country in peace since 2002, after 27 years of civil war which succeeded a 13-years war for independence. Its population is estimated to be 34.1 million people in 2023, with a total fertility rate of 5.1 births per woman and a life expectancy at birth of 63.2 years — which has steadily increased in the past decade¹⁷.

Despite its challenges, the country has improved its maternal and child health indicators over the last decade — albeit at a slow pace. Maternal mortality decreased from 281 deaths per 100 000 live births in 2012 to 241 deaths in 2017 (Figure 1) — according to the most recent data by the WHO. The government's General State Accounts (CGE; *Conta Geral do Estado*) provide further input on the topic by reporting that institutional maternal mortality has continued to decline and now stands at 199 deaths per 100 000 live births (2022) — which effectively represents a 29% decline in ten years. The successful reduction in maternal deaths is accompanied by a consistent decrease in neonatal, infant and under-five mortality rates. All of which have gone down by 30%, 19% and 28%, respectively, between 2012 and 2020 (Figure 1). Such improvements have naturally contributed to the current annual population growth rate of 3%¹⁸.

Nevertheless, maternal and child mortality remains a major challenge to be overcome. This is underscored by the fact that, globally, Angola was one of the ten countries with the highest under-five mortality in 2019¹⁹. Direct obstetric cause of deaths (including gestational hypertensive disorders, antepartum hemorrhage and postpartum hemorrhage), as well as embolisms, account for a large proportion of maternal deaths in the country²⁰. In 2019, Angola's universal healthcare services coverage score was 38.7%, according to the WHO²¹.

¹⁷ INE, [Projeção da População 2014—2050](#).

¹⁸ INE, [Projeção da População 2014—2050](#).

¹⁹ Perin et al., [Global, regional, and national causes of under-5 mortality in 2000-19: an updated systematic analysis with implications for the Sustainable Development Goals](#). *Lancet Child Adolescent Health* (2022)

²⁰ Japan International Cooperation Agency. *Data Collection Survey on the Health System in Angola* (2021)

²¹ WHO, [Maternal, Newborn, Child and Adolescent Health and Ageing, Data portal](#)

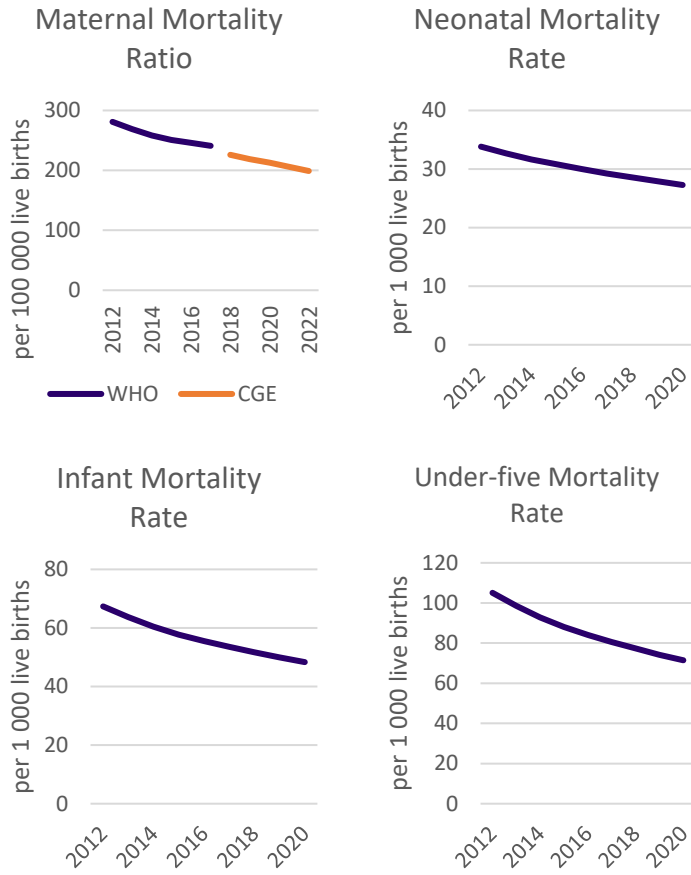


Figure 1. Maternal and Child Health Indicators. Source: WHO, Maternal, Newborn, Child and Adolescent Health and Ageing: Data portal (blue line); CGE 2018 – 2022 (orange line).

Angola's top 10 causes of death in 2019²² were, in order according to the number of deaths, the following: neonatal disorders, HIV/AIDS, diarrheal diseases, lower respiratory infections, tuberculosis, malaria, stroke, ischemic heart disease, road injuries and cirrhosis. These causes of death highlight a population in epidemiologic transition, between communicable and noncommunicable diseases. Comparison of the main causes of DALY (Disability Adjusted Life Years) between 1990 and 2019 (last available data) shows a rise in burden of noncommunicable disease while communicable diseases are declining. This may be caused by an increase in the elderly population (>65 years old), which currently represents 2.5% of the Angolan people as opposed to roughly 2.0% in 1990²³.

In 2019, malnutrition was identified as the leading risk factor for attributable DALYs in Angola²⁴. This highlights the importance for Angola to strive towards the global targets for the key nutrition indicators presented in the WHO Global Nutrition Targets 2025 (2014)²⁵ and the WHO/UNICEF Extension of the 2025 Maternal, Infant and Young Child Nutrition Targets to 2030 (2019)²⁶.

Angola is far from achieving the targets defined in these documents for 2025 or 2030. Moreover, indicators which seemed to be within the targets are likely under-reported or have shifted away from the goal. For example, the prevalence of wasting among children under-five years of age was reported at 4.9% in 2015, while the targets were below 5% in 2025 and below 3% by 2030. However, the current value is most likely higher due to the recent acute food insecurity in the Cunene, Huila and Namibe provinces caused by drought, high food prices and locusts plagues — although there is yet no national data on the progress. In these provinces, it was estimated that about 114 000 children under the age of five suffered from wasting from April 2021 through February 2022²⁷.

The total number of people suffering from food insecurity, appears to be increasing for the past 5 years in Angola — and across SADC. Or, at best, it is being more reported now (Figure 2).

However, some progress has been made regarding the coverage of high-impact health and nutrition services that provide a continuum of care. For example, there was an increase in the percentage of women (aged 15 to 49) who had at least one antenatal visit with a health professional before giving birth from 66% in 2001 to 82% in 2016 — according to the IIMS 2016. As of 2021, 61% of women in that situation had four or

²² Institute for Health Metrics and Evaluation. Country profiles: [Angola](#)

²³ [Population Pyramid](#), multiple data sources.

²⁴ Institute for Health Metrics and Evaluation. Country profiles: [Angola](#)

²⁵ WHO, [Global nutrition targets 2025: policy brief series](#) (2014)

²⁶ WHO/UNICEF, [The extension of the 2025 maternal, infant and young child nutrition targets to 2030](#) (2019)

²⁷ Integrated Food Security Phase Classification, [Angola: Acute Food Insecurity Situation and Acute Malnutrition Situation April 2021 - March 2022](#)

more antenatal visits²⁸. Similarly, there has been an increase in the percentage of married women that use contraceptive methods from 6% in 2001 to 13% in 2016 — which reflects a growing positive impact of family planning services.

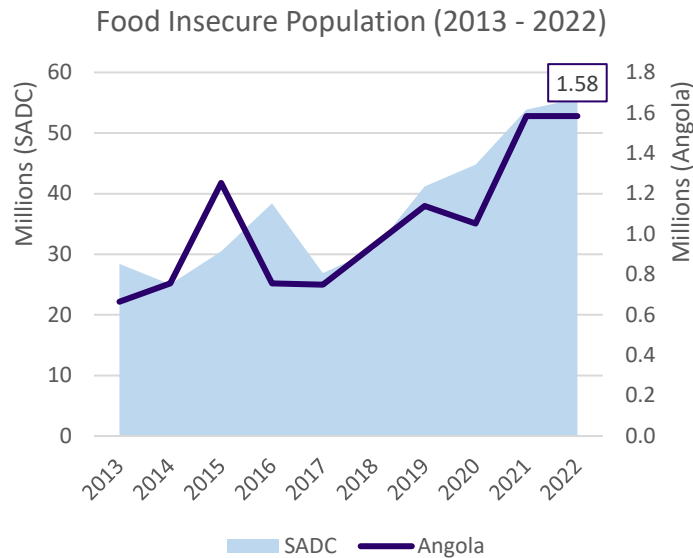


Figure 2. Food Insecure Population in SADC and Angola. Source: SADC Synthesis Report on Food and Nutrition Security and Vulnerability in Southern Africa 2018 – 2021.

The following Table 1 summarizes Angola’s key health and nutrition indicators, with a special focus on those impacting the health of children.

It is important to note though, that the last large-scale National Demographic and Health Survey (IIMS)²⁹ was performed in 2015 – 2016. This means that a large portion of the most current health and nutrition indicators are reliant on estimates based on the IIMS 2016. Since these surveys should typically have been performed over five-year periods, a new survey was expected to take place in 2019 – 2020. However, it has been delayed due to the COVID-19 pandemic to 2023.

Currently, there is a 7-year gap since the last survey took place which means that a large portion of the health data is outdated or has a questionable accuracy. Hopefully a new IIMS will be held this year to allow the clarification of the national health and nutrition situation.

²⁸ WHO, [Tracking Universal Health Coverage](#) (2021)

²⁹ Inquérito dos Indicadores Múltiplos de Saúde (IIMS; 2016).

Table 1. Summary of key health and nutrition indicators in Angola.

Health and Nutrition Indicators	Angola (2012) ³⁰	Angola (Most recent data) ³¹	Sub-Saharan Africa Average ³²	Lower- Middle Income Countries Average ³³	Targets
Maternal mortality ratio (per 100 000 live births)	281	241.0 (2017)	534 (2017)	253 (2017)	SDG ³⁴ 3.1.1: 70.0
Stillbirth rate (per 1 000 total births)	29	19.8 (2019)	—	—	—
Neonatal mortality rate (per 1 000 live births)	34	27.3 (2020)	27 (2020)	22 (2020)	SDG 3.2.2: 12.0
Infant mortality rate (per 1 000 live births)	67	48.3 (2020)	50 (2020)	34 (2020)	—
Under-five mortality rate (per 1 000 live births)	105	71.5 (2020)	73 (2020)	45 (2020)	SDG 3.2.1: 25.0
Prevalence of anaemia among women of reproductive age (% of women ages 15-49 ³⁵)	—	45.0% (2019)	41% (2019)	42% (2019)	W ³⁶ : < 14.7 (2025) W/U ³⁷ : - 50% (2030)
Prevalence of anaemia in non-pregnant women aged 15-49 years	45.3%	44.0% (2019)	40% (2019)	42% (2019)	SGD 2.2.3
Proportion of women with a live birth who received iron tablets or syrup during antenatal care	—	74.3% (2015)	—	—	—
Prevalence of anaemia in pregnant women aged 15-49 years	50.4	48.3% (2019)	46% (2019)	45% (2019)	SDG 2.2.3
Low birthweight (% of newborns who weigh <2.5 kg)	12.0%	15.3% (2015)	—	—	W: - 30% (2025) W/U: - 30% (2030)
Proportion of infants 0-5 months of age who are fed exclusively with breast milk	—	37.4% (2015)	44% (2019)	50% (2019)	W: 50% (2025) W/U: 70% (2030)
Proportion of 6- to 59-month-olds receiving two doses of vitamin A	44.0%	5.0% (2019)	35% (2020)	39% (2020)	—
Prevalence of stunting among children under-five years of age (height-for-age <-2 SD of the median)	32.4%	37.7% (2020)	32% (2020)	29% (2020)	W: - 40% (2025) W/U: - 50% (2030) SDG 2.2.1
Prevalence of wasting among children under-five years of age (% weight-for-height <-2 SD)	—	4.9% (2015)	6% (2020)	10% (2020)	W: <5% W/U: <3% SDG 2.2.2
Prevalence of overweight among children under-five years of age (weight-for-height > +2 SD of the median)	—	3.5% (2020)	4% (2020)	5% (2020)	W/U: <3% (2030) SDG 2.2.2

SD: Standard Deviation

³⁰ WHO, [Maternal, Newborn, Child and Adolescent Health and Ageing: Data portal](#)

³¹ WHO, [Maternal, Newborn, Child and Adolescent Health and Ageing: Data portal](#)

³² World Bank, [Indicators](#) (Data portal)

³³ World Bank, [Indicators](#) (Data portal)

³⁴ SDG: UN, [Sustainable Development Goals](#)

³⁵ World Bank, [Indicators](#) (Data portal)

³⁶ W: WHO, [Global nutrition targets 2025: policy brief series](#) (2014)

³⁷ W/U: WHO/UNICEF, [The extension of the 2025 maternal, infant and young child nutrition targets to 2030](#) (2019)

2.2. Public Expenditure in Health

2.2.1. The Annual Health Budget

The annual health budget in Angola has been steadily increasing for the past eight years, averaging 5.0% of the General State Budget (OGE; *Orçamento Geral do Estado*) in the last decade. This increase normally reflects an overall rise in the General State Budget, since the percentage of the health sector within the OGE is fairly stable (Figure 3). The exceptions to this rule were the years 2019 and 2023, which saw an increase of 1.6 and 1.9 percentage points (p.p.) from the previous year, respectively.

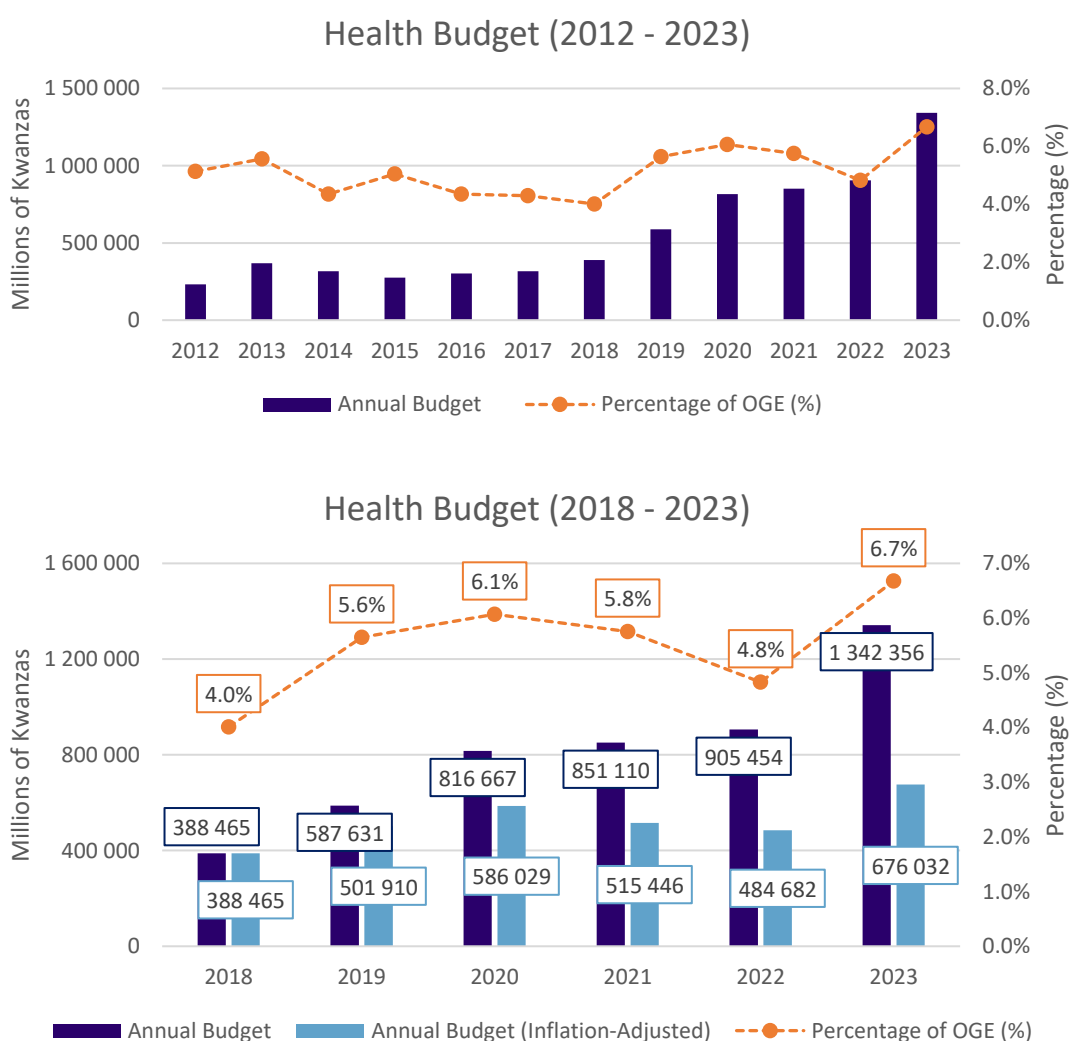


Figure 3. Health Budget. Source: OGE 2012 - 2023.

The nominal growth of the annual health budget, however, does not necessarily reflect an actual increase in investment for the sector. In fact, when looking at the past five years, if the nominal budget is adjusted for inflation, it is possible to see that the real budget has decreased since 2021, despite the continued nominal increase. Such a decrease in the inflation-adjusted budget appears to follow the reduction of the percentage of the OGE allocated to the health sector.

In 2022, the health budget represented 4.8% of the OGE and 1.6% of the Gross Domestic Product (GDP), amounting to a total of Kz 905.5 billion (US\$ 2.6 billion) or Kz 27.3 thousand per capita (US\$ 54 per capita). It was the second consecutive year where the percentage of the OGE allocated towards health was reduced.

According to the recently released budget, the health budget for 2023 represents 6.7% of the OGE – which reflects a 1.9 p.p. increase when compared to 2022 and inverts the ongoing downward trend. This is equivalent to 2.2% of the GDP, amounting to a total of Kz 1 342.4 billion (US\$ 2.7 billion) or Kz 39.4 thousand per capita (US\$ 78 per capita) – a three-fold increase in per capita budget when compared to 2018.

Closer to the Abuja Declaration

By inverting the downward tendency in the health investment as a percentage of OGE, the Government of Angola is now closer to fulfilling its commitment made in the Abuja Declaration of 2001³⁸ to allocate 15% of the annual General State Budget towards the health sector. As of 2014, only 4 countries were complying with the Abuja commitment and Angola was below the African average regarding public expenditure on Health (as a percentage of total public expenditure)³⁹.

2.2.2. Budget Execution in the Health Sector

Although the annual health budget has increased, there is a substantial gap between the budget that is initially approved and the budget that is *de facto* authorized. In fact, over the last decade, the authorized budget is on average 86.9% of the approved annual health budget (Figure 4). Between 2018 and 2020, the situation was especially critical, as the authorized budget was less than 70% of the approved budget — this means that over 30% of the budget was effectively captivated.

³⁸ Abuja Declaration (2001):

<https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf>

UNAIDS, Abuja +12 Shaping the future of health in Africa (2013):

https://www.unaids.org/sites/default/files/media_asset/JC2524_Abuja_report_en_0.pdf

³⁹ WHO, [Public Financing for Health in Africa: From Abuja to the SDGs](#) (2016)

In 2021, there was a meaningful shift in this trend and the authorized budget represented 94.9% of the approved budget.

Regarding the execution rates in the health sector (*i.e.*, the percentage of the authorized budget that is effectively executed), they have averaged 87.7% between 2012 and 2021. **There is an improvement in the rates of execution in the past five years as they have been consistently above 90%.**

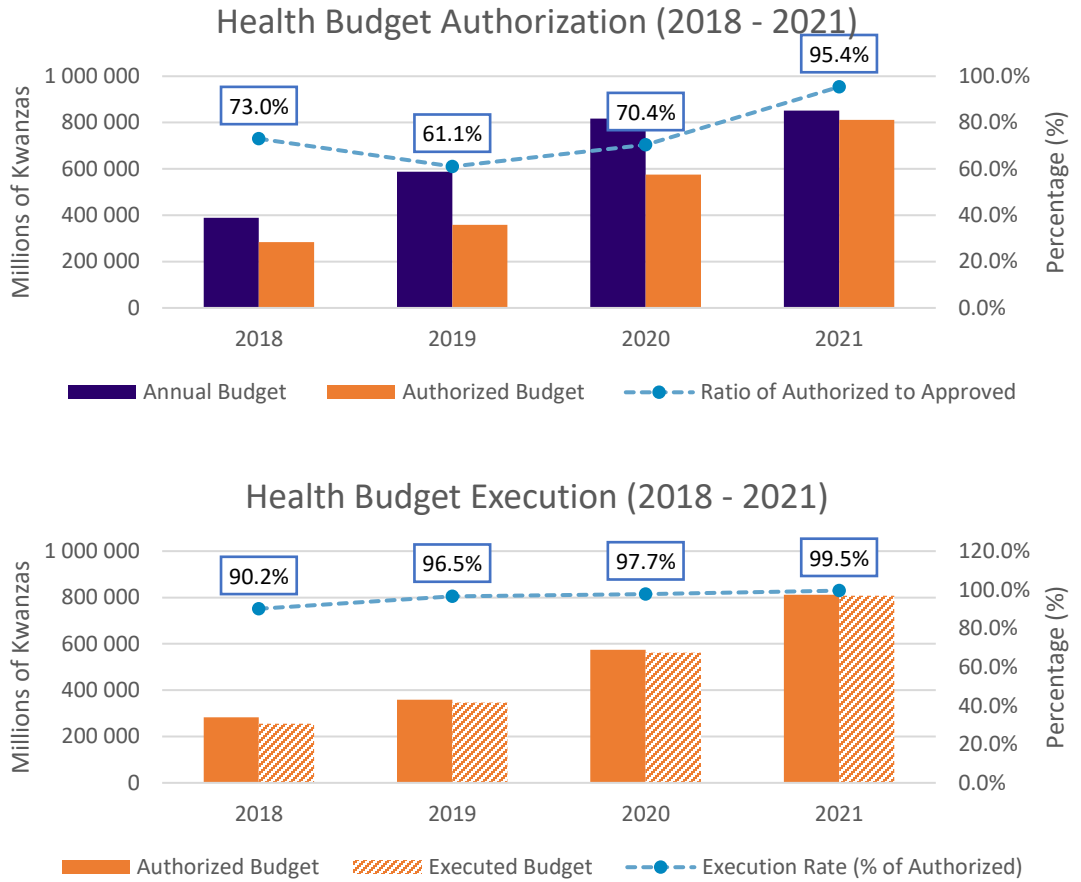


Figure 4. Health budget authorization and execution. Source: CGE 2012 – 2021.

2.2.3. Distribution of the Health Budget

The whole of the health budget is distributed by multiple Government Entities every year, according to their obligations and needs. In 2022⁴⁰, the Provincial Governments received the largest proportion of the budget (38%; Figure 5), followed by MINSA (31%) and the State Reserves (27%). The remaining entities amounted to a total of 4%.

The proportion of the health budget allocated to Provincial Governments has remained the same between 2020 and 2022, but decreased if compared to 2019 and 2018, when it was 40% and 50%, respectively.

Of the Provincial Governments, Luanda had the largest share of the funds (15%) in 2022, followed by Benguela (10%) and Huambo (8%). The remaining provinces gathered 67% of the total amount. This distribution does not change significantly between 2018 and 2022.

Luanda, in this case, is the most densely populated province in the country and when we calculate the health budget of each individual Provincial Government per Capita in 2022, it becomes the least funded province — with a budget of Kz 5.8 thousand per Capita. Bengo is the province with the highest investment adjusted for population with Kz 21.3 thousand per capita (Figure 6).

Note that the Provincial Governments have full autonomy regarding which percentage of their total budget they allocate towards health.

The executed budget per capita of each provincial government in the year before (2021) follows a similar trend, as the budget for 2022. The health expenditure in Luanda was Kz 4.3 thousand per capita, as the least funded province, behind Cuanza-Sul with Kz 5.2 thousand per capita. Bengo was the province with the highest expenditure adjusted for population in 2021, with Kz 20.7 thousand per capita (Figure 7).

According to data provided by MINFIN, Lunda-Sul (124%), Cabinda (102%) and Lunda-Norte (99%) were the provinces with the highest difference between the executed budget and the approved budget in 2021 (Figure 8). In Lunda-Sul, it is the second consecutive year where expenditure exceeds the initial budget, while in Lunda-Norte there was a substantial improvement when compared to the past three-years where expenditure was far below the budget. Cabinda's ratio of executed to approved budget ranged between 81% and 102% over the course of the four years studied here (2018 – 2021).

On the other end, Cuando-Cubango (73%), Luanda (71%) and Zaire (67%) were the provinces with the lowest percentage of executed budget. While the ratio of executed

⁴⁰ For the budget distribution per Government Entity, the data for 2023 was not analyzed since the budget had not been approved at the time of writing.

to approved budget fluctuate on an annual basis, these three provinces have consistently reported ratios below 81%. It is also worth noting that Huambo, Bié and Huíla were the three provinces whose average ratio of executed to approved budget between 2018 and 2021 was closer to 100%.

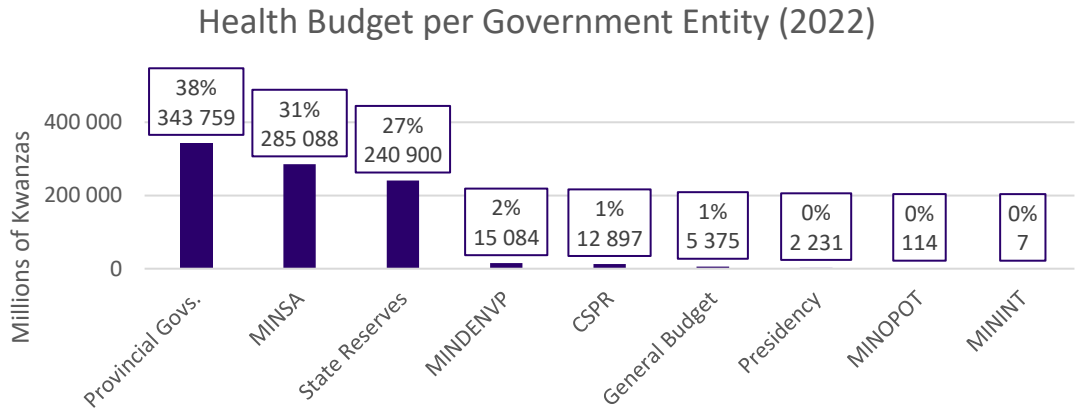


Figure 5. Health budget distribution per Government Entity. Source: OGE 2022.
CSPR: Center of Security of the President of the Republic (*Casa de Segurança do Presidente da República*)

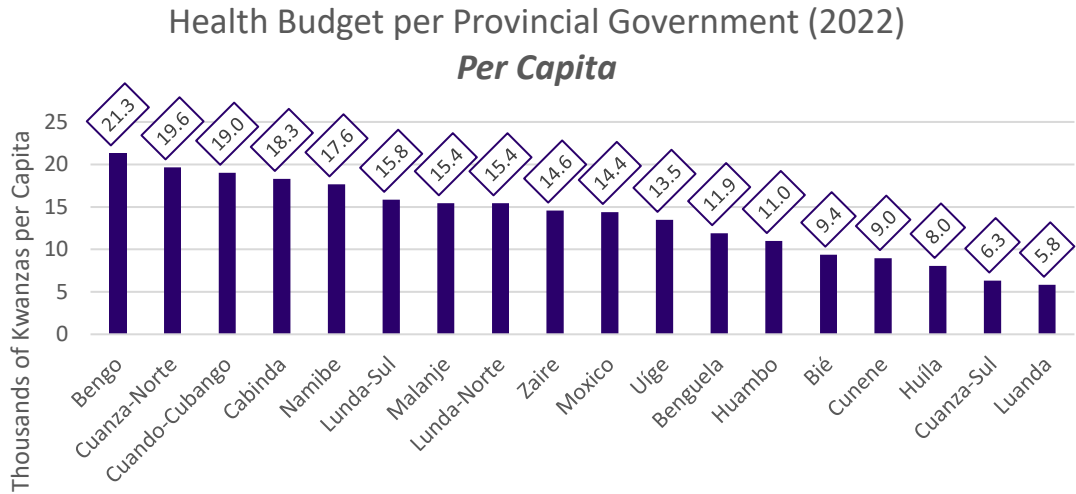


Figure 6. Health budget per Provincial Government. Source: OGE 2022.

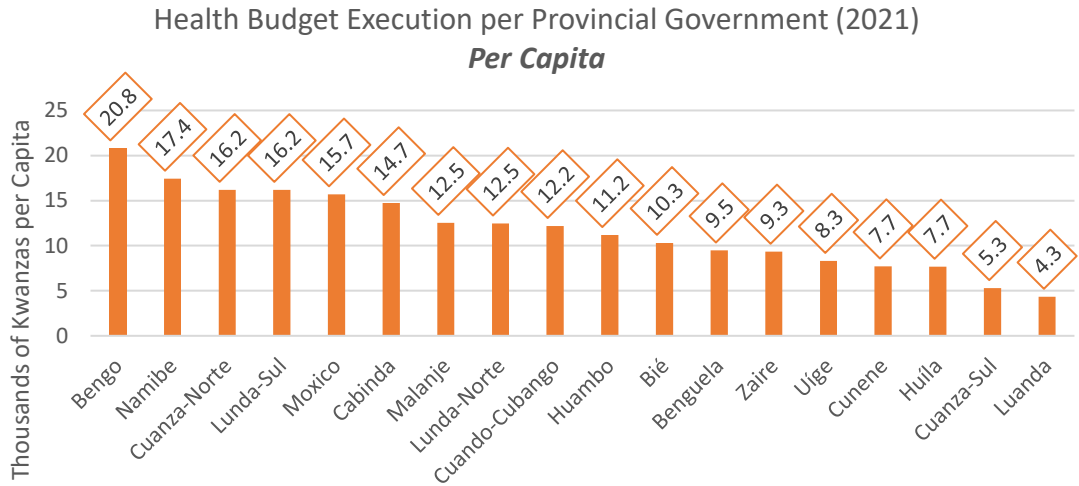


Figure 7. Health executed budget per Provincial Government. Source: Data by MINFIN (2021).

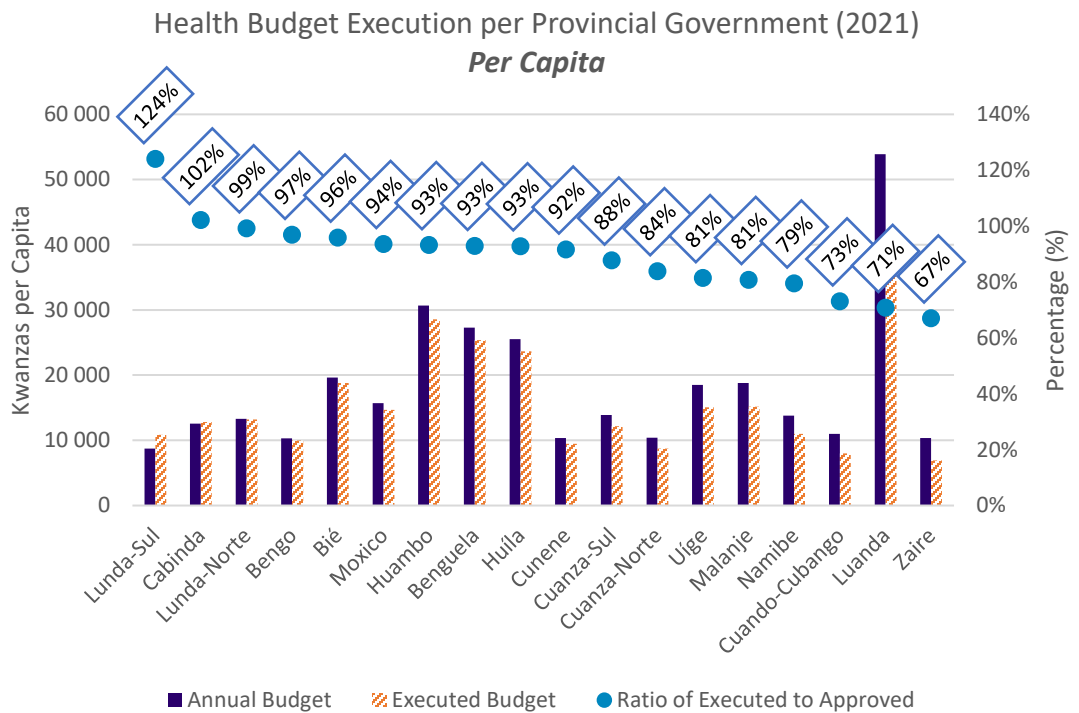


Figure 8. Health budget execution per Provincial Government. Source: Data by MINFIN (2021).

2.2.4. The Ministry of Health Budget and Execution

In the context of the General State Budget, MINSa is presented in two distinct roles. First as a state entity (*Órgão do Estado*) and second as a budgetary unit (*Unidade Orçamental*). The difference between the two being that, as a state entity, the budget for MINSa encompasses multiple budgetary units including MINSa itself, but also medical facilities including as hospitals, medical centers and institutes.

MINSa — The State Entity

The budget for MINSa, as a state entity, was Kz 305.8 billion in 2022 and represented roughly 1.6% of the OGE. Current expenses comprised 66% of the budget and capital expenses — exclusively investments — represented the remaining 34% (Figure 9). Within the current expenses, goods and services absorbed 80% of the budget and personnel expenses 19%. The remaining 1% was allocated to employer expenses and subsidies and current transfers.

Historically, current expenses have decreased, and capital expenses have increased in the last five years, due to the building of new hospitals and medical centers.

In 2022, out of the total budget allocated towards MINSa, as a state entity, 76% was allocated exclusively to MINSa, the budgetary unit (Figure 10). Thus, leaving 24% of the budget to medical facilities such as hospitals, medical centers and institutes. This was the highest share since 2018 and illustrates a trend towards budget centralization.

In 2023, the budget reached Kz 384.2 billion, the equivalent to 1.9% of the OGE, and the share of the budget allocated to MINSa, as a budgetary unit, came down to 60%.

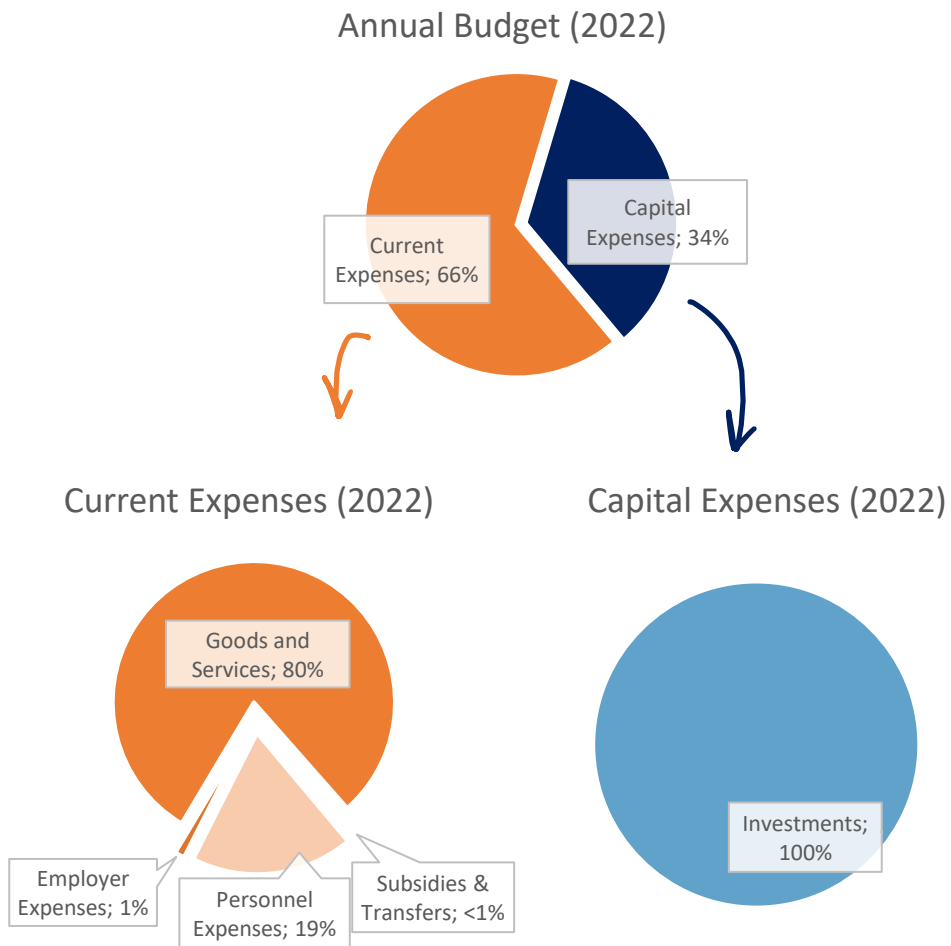


Figure 9. Ministry of Health (State Entity) Budget Composition. Source: OGE 2022.

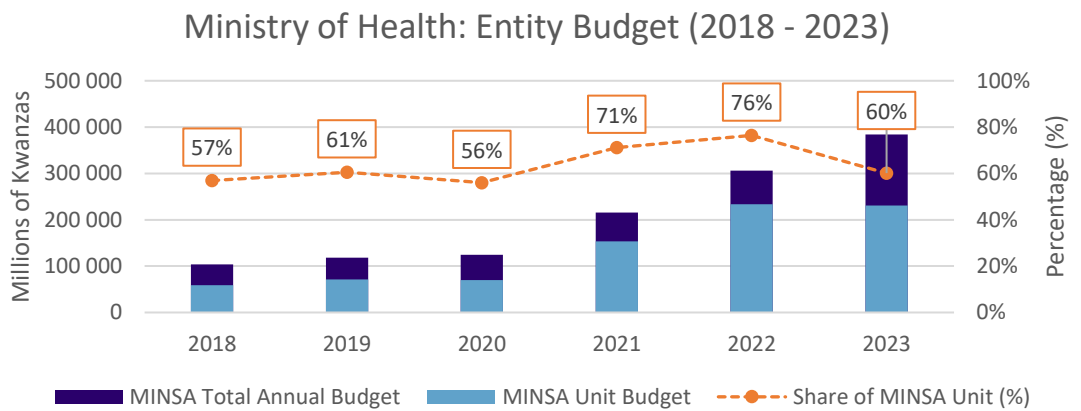


Figure 10. Ministry of Health (Entity) Budget and Share of MINSAs Unit. Source: OGE 2022.

MINSA — The Budgetary Unit

The budget for MINSA, as a budgetary unit, was Kz 233.7 billion in 2022 — or the equivalent to 1.2% of the OGE (Figure 11). As per the budget execution, data was limited to 2020 and 2021, when the Ministry executed 272% and 228% of its initially approved budget, respectively (Figure 11). This was largely driven by investment in the building and equipping of new hospitals.

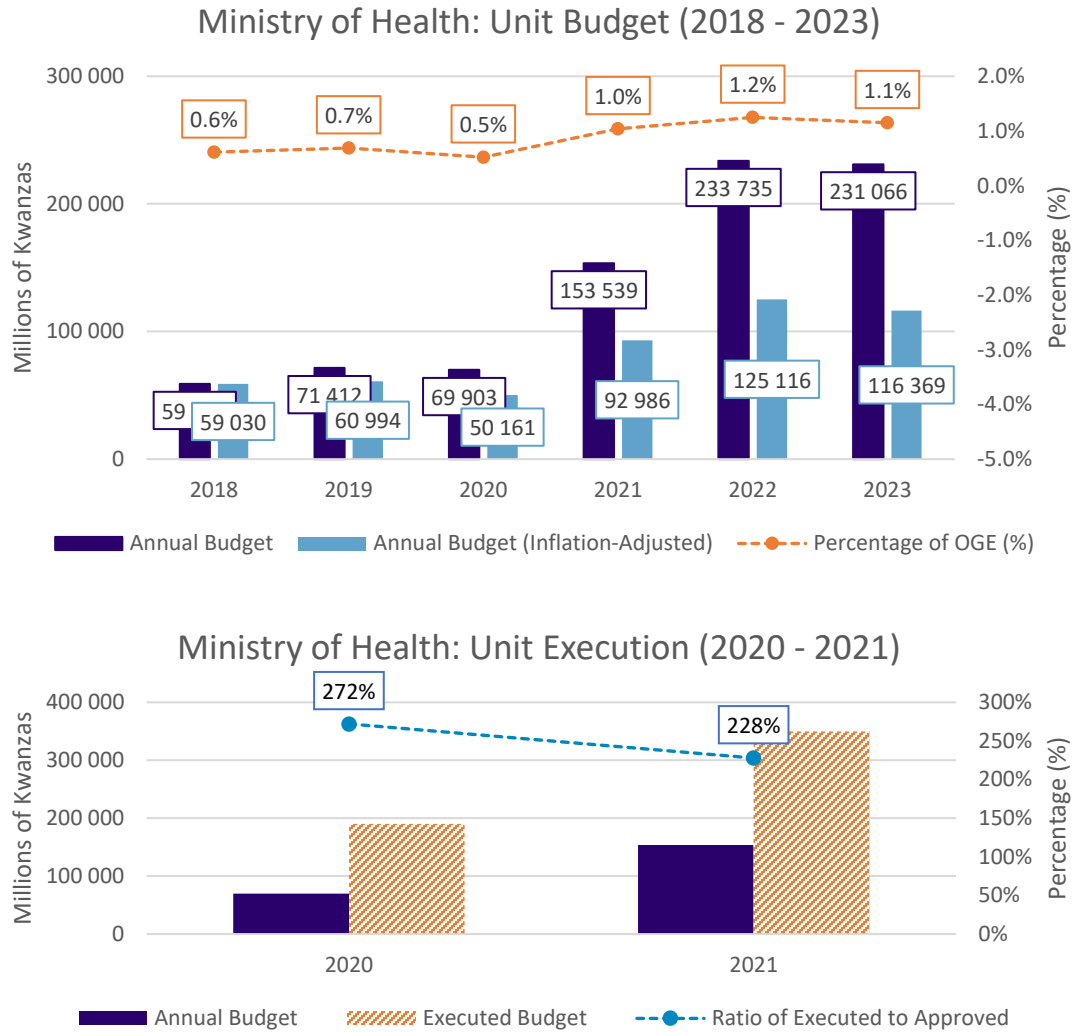


Figure 11. Ministry of Health (Budgetary Unit) Budget and Execution.

Source: OGE 2018 - 2023 and CGE 2020 - 2021.

The budget's composition in 2022, was fairly similar to that presented in Figure 9, with 56% of the budget allocated to current expenses and 44% allocated to capital expenses — exclusively investments (Figure 12). Goods and services take up the largest share of the current expenses (93%), followed by personnel expenses (6%). The remaining 1% was allocated to employer expenses and subsidies and current transfers.

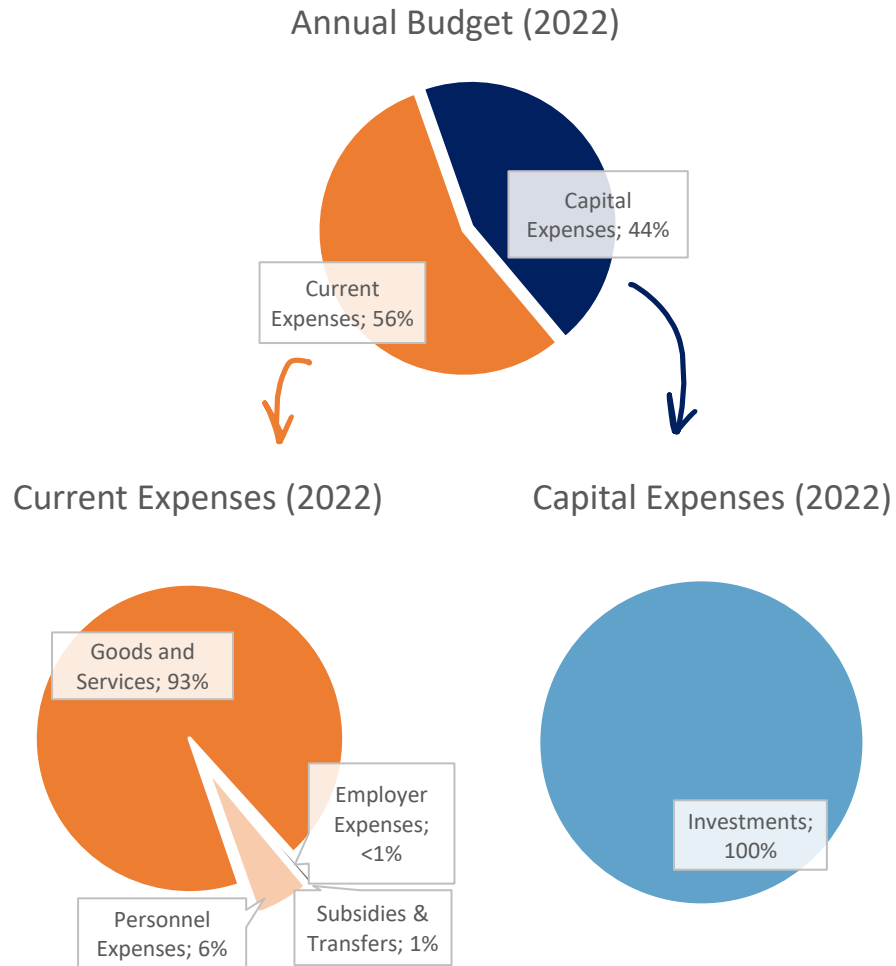


Figure 12. Ministry of Health (Budgetary Unit) Budget Composition. Source: OGE 2022.

It's important to note that data on the budget execution for the remaining budgetary units such as hospitals, medical centers and institutes was not available (with a few exception).

2.2.5. Composition of the Health Budget

Health constitutes a budget function within the General State Budget, which has been further divided into 6 budget sub-functions, as illustrated bellow (Figure 13).

These are 1) General Hospital Services, 2) Specialized Hospital Services, 2) Medical and Maternity Centers Services, 4) Public Health Services, 5) Products, Devices and Medical Equipment, and finally 6) Outpatient Services.

Although budgetary lines are not static, these six sub-functions have remained constant within the last decade.

A seventh sub-function titled Non-specific Health Services was additionally present in the OGE of 2012 but was removed thereafter. A positive sign of increasing budget accuracy. As such, it will be accounted for when calculating the total health budget of that year, but it will not merit any further analysis.

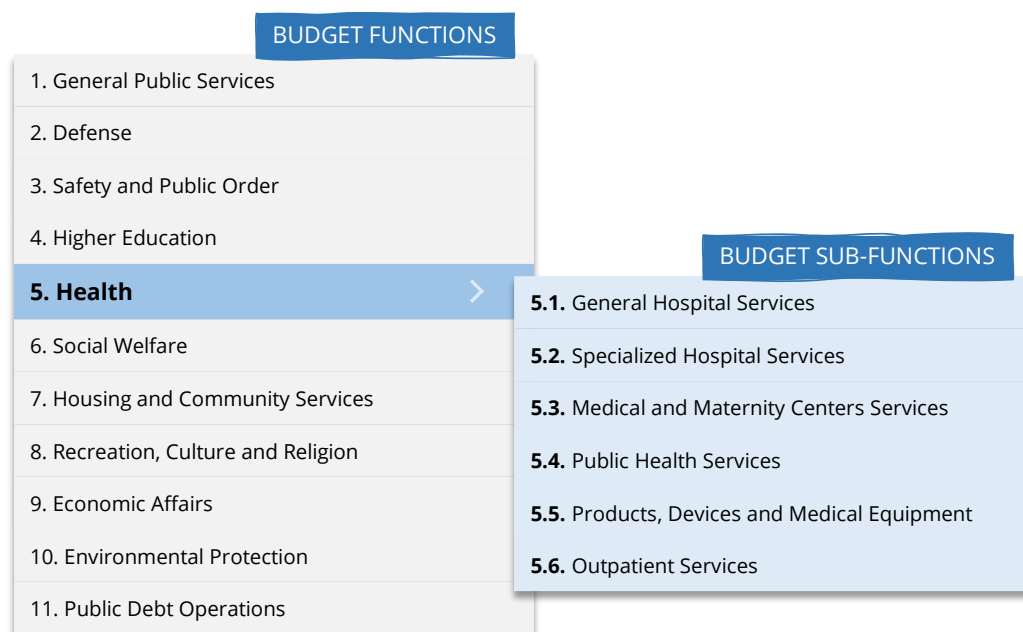


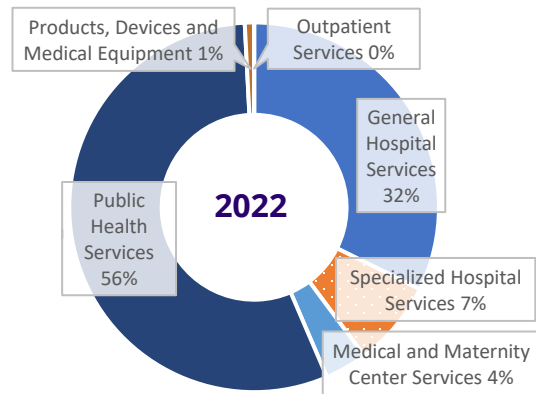
Figure 13. General State Budget item breakdown.

The budget allocated to each of these sub-functions varied over the last ten year, as did the share of the annual health budget that each of them represented (Figure 14 and 16). General Hospital Services and Public Health Services are by far the two largest components of the health budget — having a combined representation of over 60% since 2013. However, while General Hospital Services was initially the dominant expenditure, Public Health Services has become the largest component as of 2016.

On the other hand, Products, Devices and Medical Equipment, as well as Outpatient Services are two of the least invested in components — having a combined representation of less than 1% annually. These two have seen a significant decline since 2013. In the case of Outpatient Services, the budget previously allocated towards this component has been incorporated into Public Health Services, in 2023, to eliminate redundancies in the budget.

In 2022, Public Health Services represented over half (56%) of the health budget and General Hospital Services represented roughly one third (32%). They were followed by Specialized Health Services and Medical and Maternity Centers Services with a share of 7 and 4%, respectively. The remaining two components amounted approximately to 1%.

Components of the Health Budget



In 2023, Public Health Services remains the largest component of the health budget by far (60%), followed by General Hospital Services (28%). Specialized Hospital Services and Medical and Maternity Center Services changes -1 p.p. and +1 p.p. respectively, while the funding for Products, Devices and Medical Equipment remained 1%. The most evident difference has been the effective removal of Outpatient Services as a component.

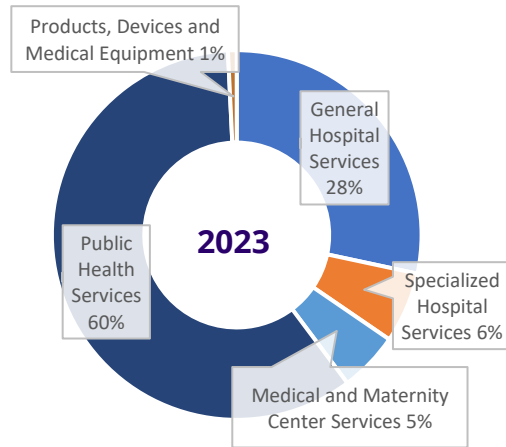


Figure 14. Components of the health budget. Source: OGE 2022 – 2023.

Components of the Health Budget

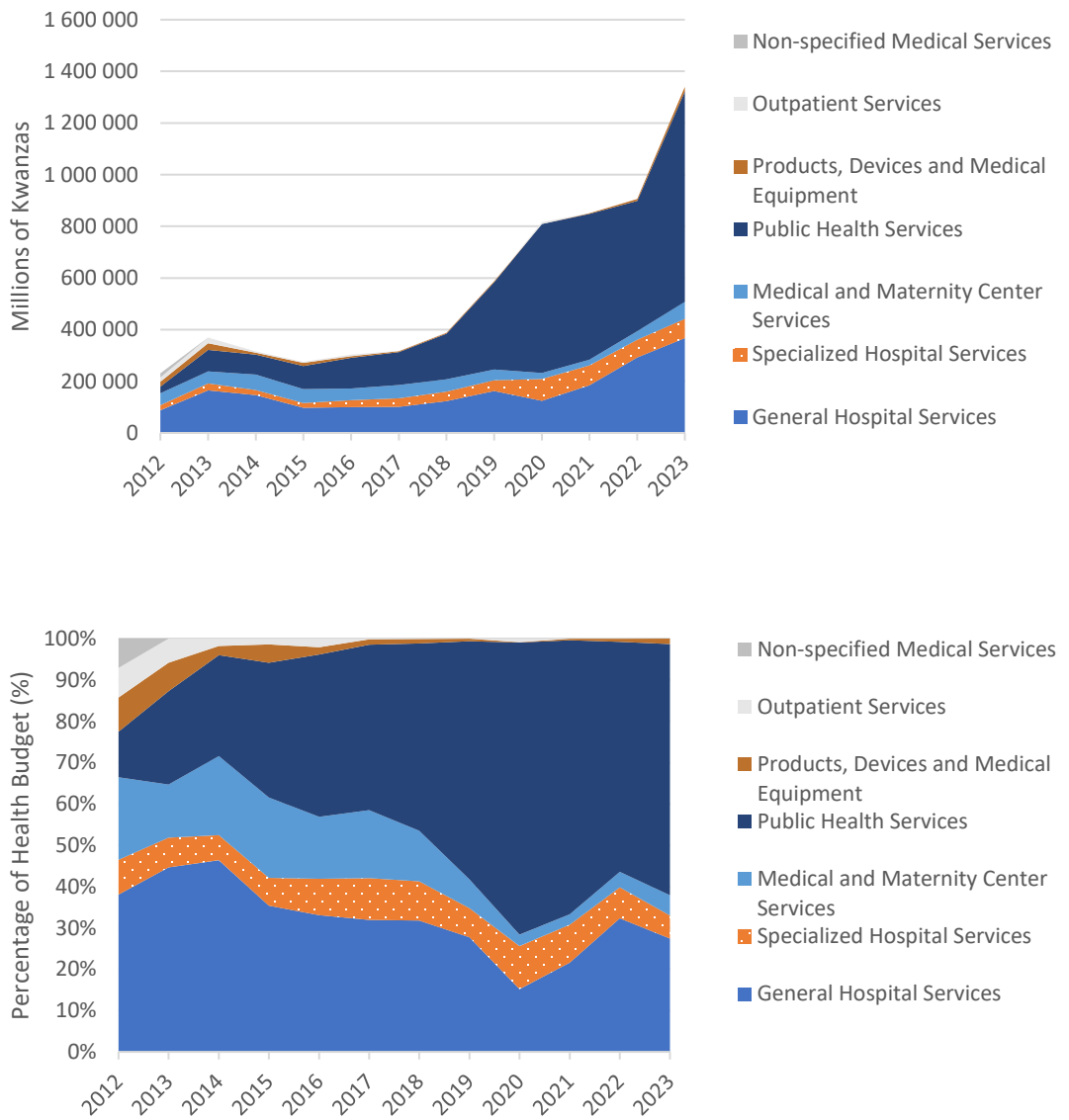


Figure 15. The Components of Health. Source: OGE 2012 - 2023.

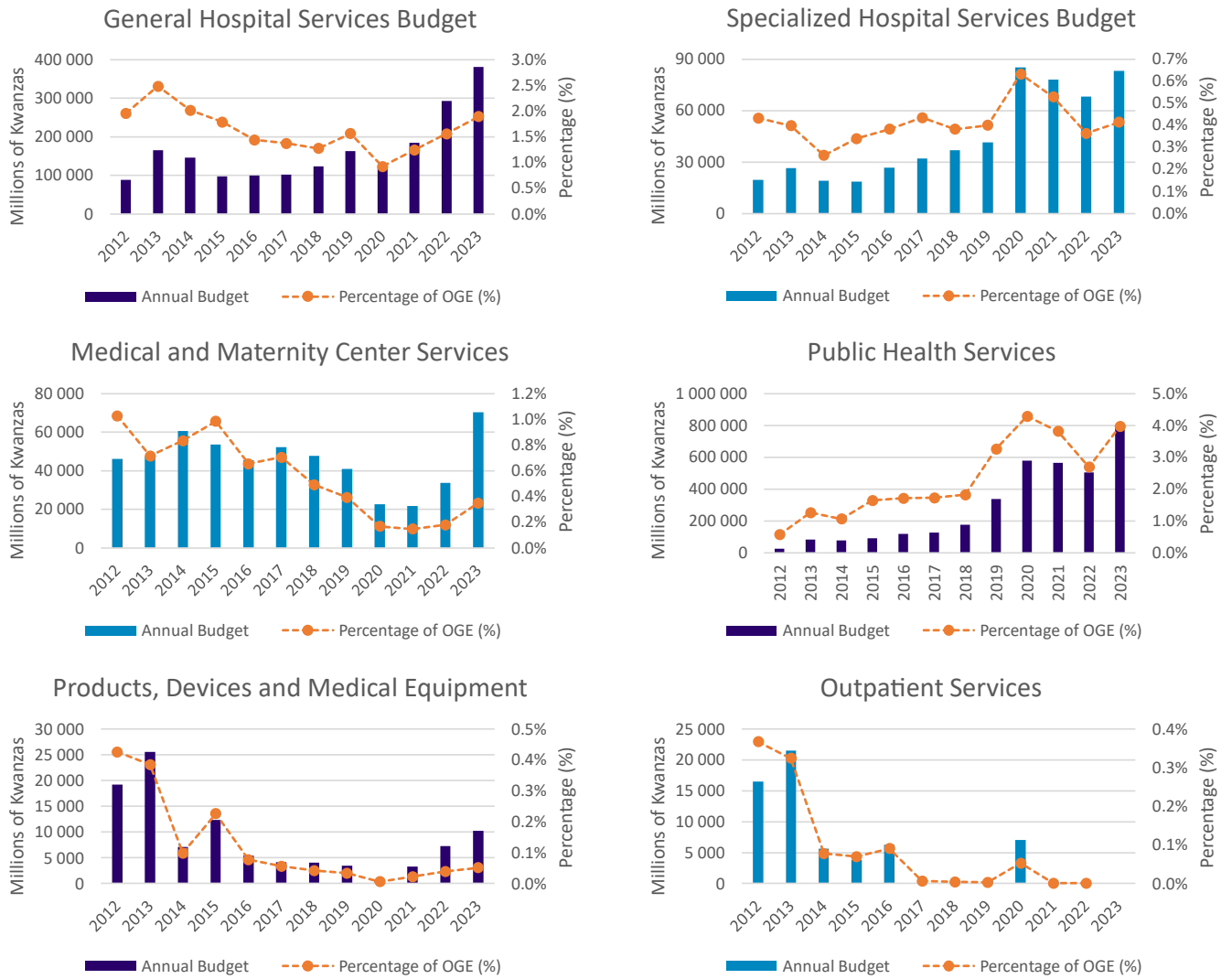


Figure 16. Overview of the Budget for the Components of Health. Source: OGE 2012 – 2023.

2.2.6. Health Programs

In parallel with the budget functions, the state also allocates expenditure to development programs. These programs are distinct from the budget functions, but they are not additive to them, which means that they are linked. However, the relationship between the two is not entirely clear. The programs may contribute to one or more of the budget functions and thus, their framing requires a case-by-case analysis, which was a challenge faced during the development of this report.

In our analysis, **we have identified 12 health programs within the last decade** (2012 — 2023; *Table 1*).

Table 2. Health Programs. Source: OGE 2012 – 2023.

Health Programs	
<i>Ongoing programs</i>	
1. Improvement of Medical and Medication Assistance	2019 – 2023
2. Improvement of Maternal and Child Health and Nutrition	2012 – 2023
3. Fight Against Major Endemic Diseases Through Health Determinants Approach	2012 – 2023
4. Strengthening of the Health Information System and Development of Health Research	2019 – 2023
<i>Former programs</i>	
5. Provision of Health Care	2014 – 2019
6. Improvement of the Quality of Health Services	2012 – 2018
7. Dev. of the Pharmaceutical Sector and Management of Medical Devices	2014 – 2018
8. Management and Dev. of the Supply and Logistics of the Health Sector	2014 – 2018
9. Public Veterinary Health	2014 – 2018
10. Provision of Primary Care and Hospital Assistance	2013 – 2017
11. Development of Health Services	2012 – 2013
12. Improvement and Capacity Building of Hospital Services	2012

Looking into these programs, it becomes clear that there is a change between 2018 and 2019 – which coincides with the change in the political cycle. The restructuring of programs likely reflects an aggregation of multiple programs into a single broader program, namely the Program for the Improvement of Medical and Medication Assistance, whose budget is within the same order of magnitude as the sum of the programs terminated in 2018 and 2019.

Currently, there are four ongoing programs, two which have existed since 2012 (*i.e.*, ‘Improvement of Maternal and Child Health and Nutrition’ and ‘Fight Against Major Endemic Diseases Through Health Determinants Approach’) and two which were created in 2019 (*i.e.*, ‘Improvement of Medical and Medication Assistance’ and ‘Reinforcement of the Sanitary Information System and Development in Health Research’). Regarding the total accumulated budget of these programs over the course of the last decade, it generally follows the same trend as the annual health budget (Figure 17), as expected. On average, it is equivalent to roughly one-quarter of the health budget (26%), but it has been as high as 44% in 2012 and as low as 16% in 2015.

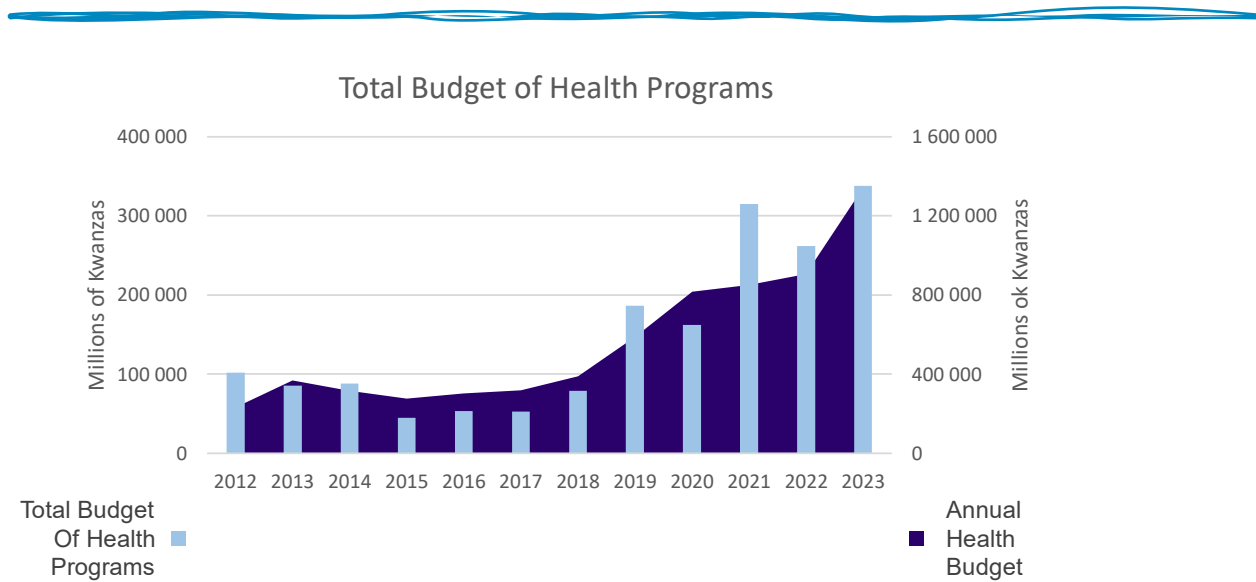


Figure 17. Total budget of health-related programs vs. annual health budget.

Source: OGE 2012 – 2023.

2.2.7. Total Health Expenditure and Sources of Financing

Total Health Expenditure in Angola in 2020 was Kz 980.8 billion (US\$ 1.7 billion)

— according to data provided by the Government of Angola to the WHO — Global Health Expenditure database⁴¹. This represents 2.9% of the country's GDP; far below the average of the WHO African region (5.5%). In fact, in terms of Total Health Expenditure as a percentage of GDP, Angola ranks 45th out of 47 African nations.

Domestic General Government Expenditure (*i.e.*, the executed budget for 2020) represented 42% of the Total Health Expenditure that year. It was the second largest source of financing following Domestic Private Health Expenditure, which represented 54%. External Health Expenditure (or External Aid), provided by multilateral organizations and donors, represented the remaining 4% (Figure 18).

Domestic Privates sources can be further divided into Out-of-Pocket Expense (37%) — that is expenses paid by individuals that may or may not be reimbursed later, Voluntary Health Insurance Contributions (7%) and other sources (10%).

The percentages of each source of financing have remained stable in the past 5 years.

Out-of-Pockets Expenses are a good indicative of how high the economic burden of health on households is. Angola, where Out-of-Pocket Expenses are 37% of the Total Health Expenditure, is slightly above the average for the WHO African region, which is 34% — ranking 19th/ 47. Meanwhile, these expenses are equivalent to US\$ 19 per capita in Angola, which is significantly below the African average of US\$ 31 per Capita — ranking 27th/ 47.

A high representation of Out-of-Pocket Expenses in the Total Health Expenditure, aligned with a low Out-of-Pocket Expenditure per capita highlight the fact that Angola's Total Health Expenditure is overall low when compounded with its growing population.

⁴¹ WHO, [Global Health Expenditure database](#)

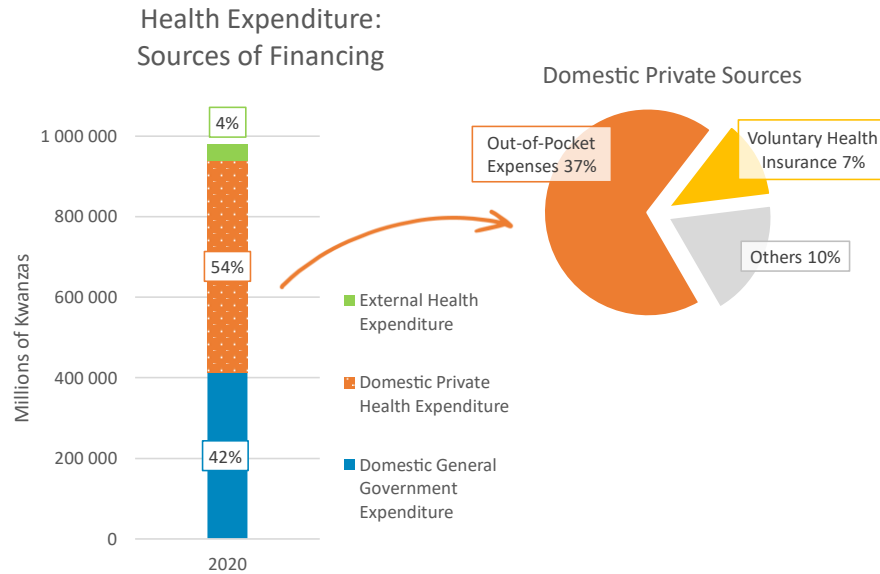


Figure 18. Sources of Financing of Health Expenditure.
Source: WHO, Global Health Expenditure database (2020).

2.3. Public Expenditure in Nutrition

2.3.1. Understanding the Types of Nutrition Interventions

Studying the budget for nutrition is not as simple as looking into health expenditure, since nutrition is not a budget function in itself, nor is it a sub-function within the health budget.

This is a challenge that is not specific to Angola, it is a global challenge and a consequence of the multi-sectoral nature of nutrition interventions.

To address this issue, our approach will be based on a framework previously established on the *Lancet* Series on Maternal and Child Nutrition of 2013⁴² (Figure 19), which shows the means to optimum fetal and child growth and development that is applied by the Scaling-Up Nutrition (SUN) Movement. This framework describes three types of interventions on nutrition:

- I. **Nutrition-specific:** Interventions that address the immediate causes of suboptimum growth and development, and therefore have a direct and high-impact on nutrition. These normally comprise health-based approaches such as dietary and micronutrient supplementation, and malnutrition treatments;

⁴² Lancet. [Maternal and Child Nutrition Series](#) (2013)

- II. Nutrition-sensitive:** Interventions that address underlying causes and determinants of malnutrition with nutrition-relevant objectives and actions, and therefore have an indirect impact on nutrition. These normally include investments that focus on agriculture and increasing food security, social welfare and that contribute toward the water, sanitation and hygiene (WASH) sector;
- III. Nutrition-enabling:** Interventions that enhance and improve the governance of the sector, therefore building an environment that supports the development of the other two types of nutrition interventions.

Using this framework, we have analyzed the programs presented in the OGE of Angola and identified those which match the definition of nutrition-specific, -sensitive, and enabling interventions. The selection was based on two criteria:

- 1) The performance indicators (objectives) defined for each program in the OGE and CGE;
- 2) The impact on nutrition of these programs, given the specific socioeconomic context of Angola.

Between 2019 and 2023, we have identified a total of 14 nutrition-related programs. One nutrition-specific program (*i.e.*, Improvement of Maternal and Child Health and Nutrition), which also has nutrition-sensitive components, 11 nutrition-sensitive programs and 2 nutrition-enabling programs. Within the exclusively nutrition-sensitive programs, these are further subdivided into the farming sector (4), social welfare (4) and WASH sector (3).

The list can be visualized in Table 3, where the programs are associated with the types of intervention undertaken – within the context of Angola.

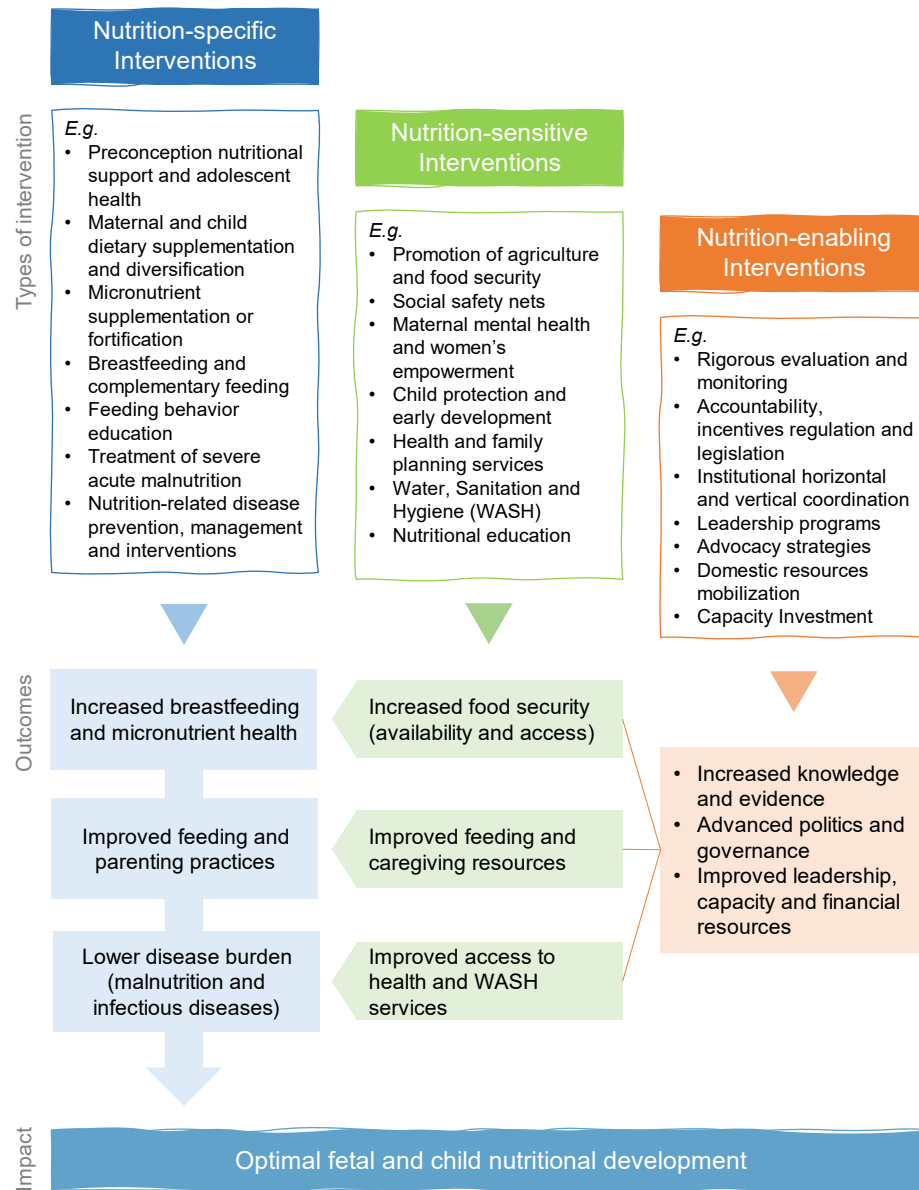


Figure 19. Nutrition Interventions Framework. Adapted from Bhutta, et al. (2013), Lancet.

Table 3. Nutrition-related programs. Source: OGE 2019 – 2023.

Categories	Interventions	Programs
Nutrition-specific	<ul style="list-style-type: none"> • Preconception nutrition support and adolescent health • Micronutrient supplementation or fortification • Nutrition-related disease prevention, management and interventions • Treatment of severe acute malnutrition 	1. Improvement of Maternal and Child Health and Nutrition Program
	<p>Social welfare:</p> <ul style="list-style-type: none"> • Health and family planning services 	2. Local Development and Poverty Alleviation
Nutrition-sensitive	<p>Social welfare:</p> <ul style="list-style-type: none"> • Social safety nets • Child protection and development 	3. Protection and Promotion of Children's Rights
		4. Valuing the Family and Strengthening Family Skills
		5. Modernization for the Obligatory Social Protection System
		6. Promotion of Agricultural Production
		7. Promotion of Livestock Production
	<p>Farming:</p> <ul style="list-style-type: none"> • Promotion of agriculture and food security 	8. Sustainable Exploitation of Living Aquatic Resources and Salt
Nutrition-enabling		9. Development of Sustainable Aquaculture
		10. Improvement of Basic Sanitation
	<p>WASH:</p> <ul style="list-style-type: none"> • Water, Sanitation and Hygiene 	11. Expansion of Water Supply
		12. Development and Consolidation of the Water Sector
Nutrition-enabling	<ul style="list-style-type: none"> • Rigorous Evaluation and monitoring • Accountability, incentives regulation and legislation • Institutional horizontal and vertical coordination • Capacity Investment 	13. Improvement of Food and Nutritional Security
		14. Reinforcement of the Sanitary Information System and Development in Health Research

It is important to highlight that the Program for the Improvement of Maternal and Child Health and Nutrition also includes nutrition-sensitive interventions. However, it is only possible to distinguish between the budget allocated to nutrition-specific interventions and that allocated to nutrition-sensitive interventions as of 2022 — when the government first began to publish data on the financing of the program's performance indicators (objectives).

We have considered that interventions within the scope of the following indicators (set for 2022 and 2023) are nutrition-specific:

- i) Pregnant woman with 4 antenatal visits;
- ii) Health units with comprehensive child care consultation;
- iii) Pentavalent immunization coverage;
- iv) Under-five malnutrition rate.

While interventions within the following indicators are nutrition-sensitive:

- i) Health units offering at least 3 modern methods of family planning;
- ii) Municipalities with integrated adolescent care services.

The remaining indicators were not considered in the nutrition budget since they fall within the scope of general health. Prior to 2022, the program as a whole was considered nutrition-specific due to the limitation on data explained before.

See Chapter 3 for an in-depth analysis of this program and its indicators.

2.3.2. The Annual Nutrition Budget

Based on the program selection described in the previous chapter, the budget for nutrition in 2022 (Figure 20) was Kz 529.0 billion (US\$ 1.1 billion) — which represented 2.8% of the OGE and Kz 16.0 thousand per capita (US\$ 34.7 per capita). Nutrition-specific interventions comprised 1.6% of the budget, while nutrition-sensitive interventions represented 97.8%. This is a ratio of specific-to-sensitive of 1.7% (1/60). As per nutrition-enabling interventions, they covered the remaining 0.5% of the budget.

In 2023, there has been an increase in the planned expenditure for nutrition up to Kz 660.7 billion (US\$ 1.3 billion) — representing 3.3% of the OGE and Kz 19.4 thousand per capita billion (US\$ 38.5 per capita). As a whole there is currently a larger focus on nutrition-specific interventions, which represent 5.1% of the nutrition budget, while sensitive interventions amount to 94.2%. A ratio of 5.4% (approximately 1/18). The remaining 0.7% are covered by nutrition-enabling interventions.

Historically, the budget allocated for nutrition has been steadily increasing (Figure 21), as nutrition becomes a more relevant part of the OGE — a positive sign of the augmented awareness for the subject.

This increase is also observed in 2022, even though (as previously explained) the Program for the Improvement of Maternal and Child Health and Nutrition was not considered as 100% nutrition-related, unlike in previous years.

The next step now is to raise Angola’s investment in nutrition to match that of the African average (Figure 22).

Nutrition Program-based Budget (2022 - 2023)

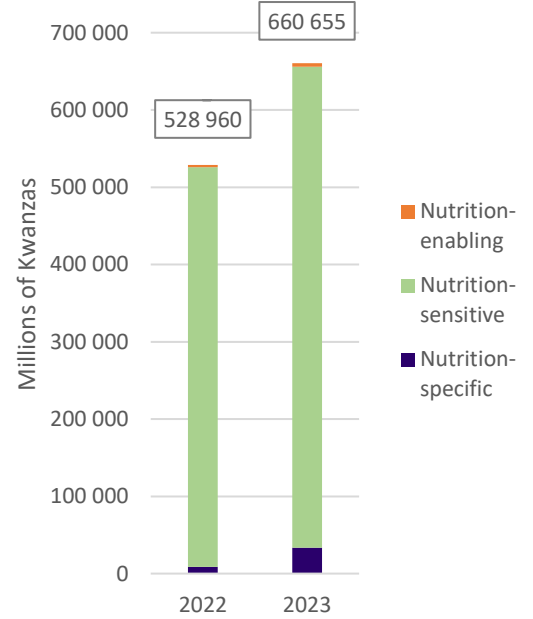


Figure 20. Nutrition budget based on development programs (2022 - 2023).
Source: OGE 2022 - 2023.

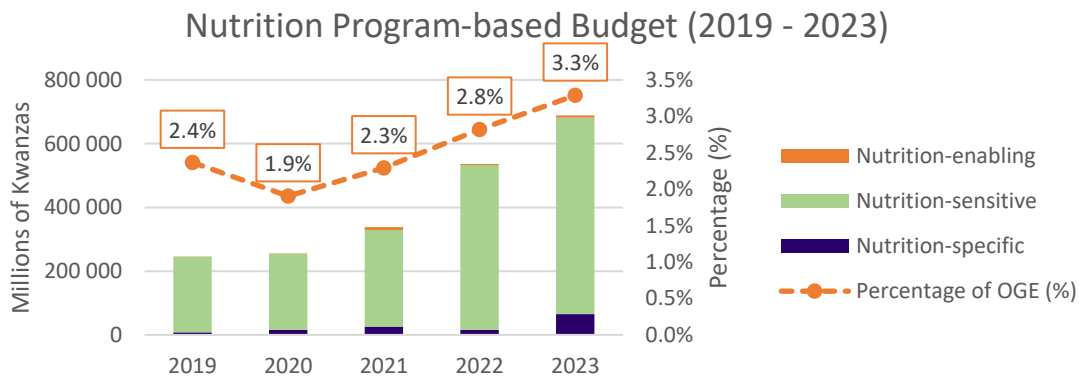


Figure 21. Nutrition (nominal) budget based on development programs (2019 - 2023).
Source: OGE 2019 - 2023.

Nutrition Allocation per Country (% of OGE)

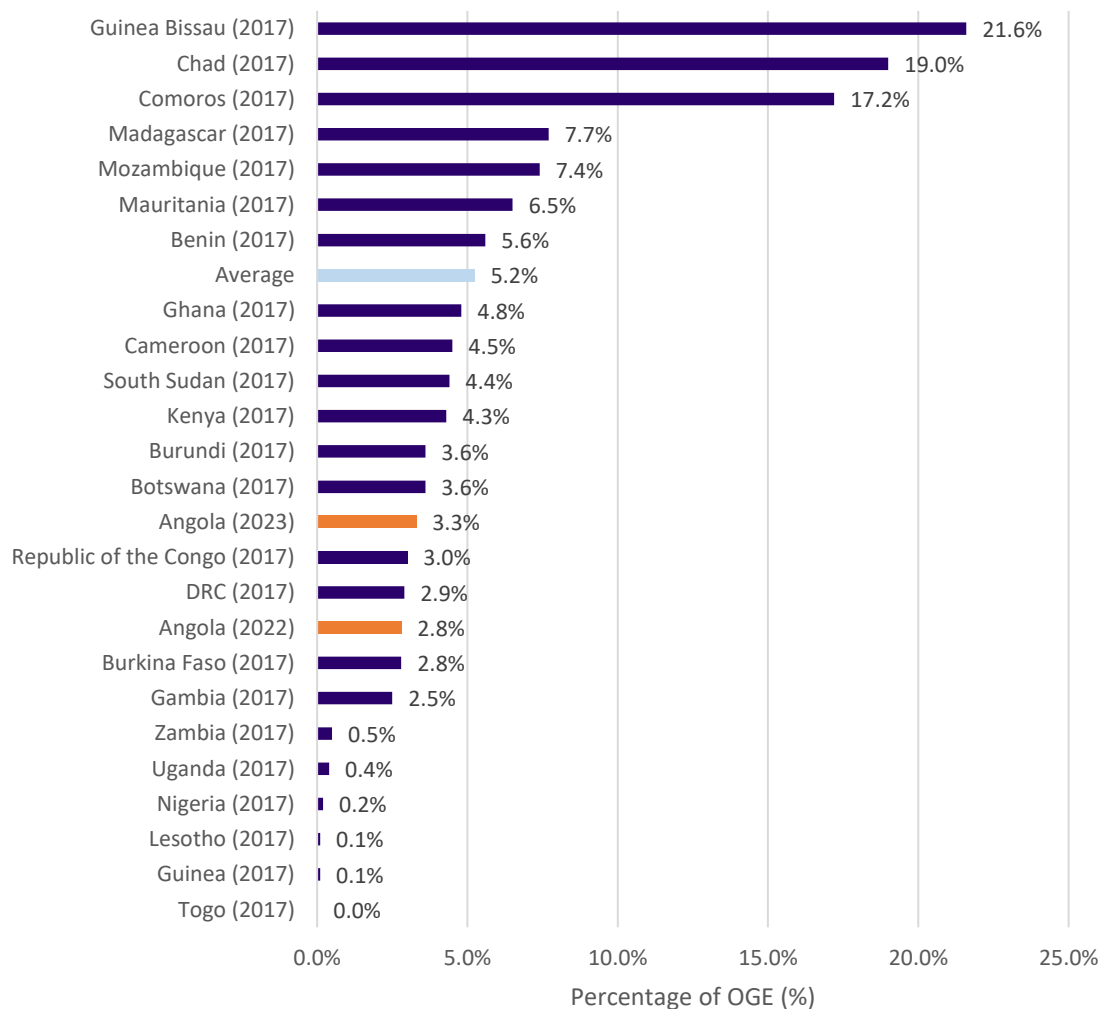


Figure 22. Nutrition allocation as a Percentage of OGE per Country. Source: 2017 Global Nutrition Report.

According to the data reported by multiple African countries to the SUN Movement between 2015 and 2017, which was presented in the 2017 Global Nutrition Report⁴³, the average percentage of the OGE allocated for nutrition (including specific and sensitive interventions⁴⁴) among 23 African nations was 5.2%.

⁴³ [2017 Global Nutrition Report](#)

⁴⁴ Nutrition-enabling interventions were either not considered in this report or included in the nutrition-sensitive interventions.

Angola was not part of the cohort at the time, however if we are to compare the same data with the calculations presented in this review, Angola ranks as 14 out of 24 countries — below average — with an allocation of 3.3% for 2023, or 16 out of 24 with an allocation of 2.8% in 2022. Furthermore, if we consider that since 2017 countries have made positive progress, it becomes clear that the budget for nutrition is comparatively low.

As per the ratio between nutrition-specific and nutrition-sensitive interventions, the 2017 Global Nutrition Report also provides some basis for comparison, although the hard data was not accessible.

Nutrition-sensitive investment is always higher than nutrition-specific investment, not only in Africa but globally. This is a result of the broad investments governments make on agriculture, social welfare and the WASH sector — which together will always be higher than investment specifically directed towards maternal and child health or nutrition-related medical interventions.

Among 26 African countries (a larger cohort than before), only South Sudan has a ratio specific-to-sensitive investment above 10%, while 13 countries have a ration below 1%. Angola has a ratio of 1.7% in 2022, which has now been raised up to 5.4% in the 2023 budget.

The upward trend in the nutrition budget in Angola is a positive sign that the government is ever more aware of the importance of these interventions and willing to fund them.

A note on methodology:

A direct comparison cannot be drawn between this review and the 2017 Global Nutrition Report data due to the time lapse between them and the fact our methodology is adapted to Angola's public expenditure reporting mechanisms. Namely, that the budget calculated was based on the development programs of the Government of Angola. However, the categorization of interventions according to the framework presented in Figure 22 is similar enough between the two that indirect comparisons are still viable.

2.4. General and Specialized Hospital Services

2.4.1. General Hospital Services

The budget for General Hospital Services has been increasing for 4 consecutive years, since 2020. This can be partially explained by the fact that new hospitals have been built in the past five years. According to budget for 2023, these services will represent 1.9% of the OGE — equivalent to Kz 381 billion (Figure 23). While the budget for last year was Kz 293 billion, or 1.6% of OGE.

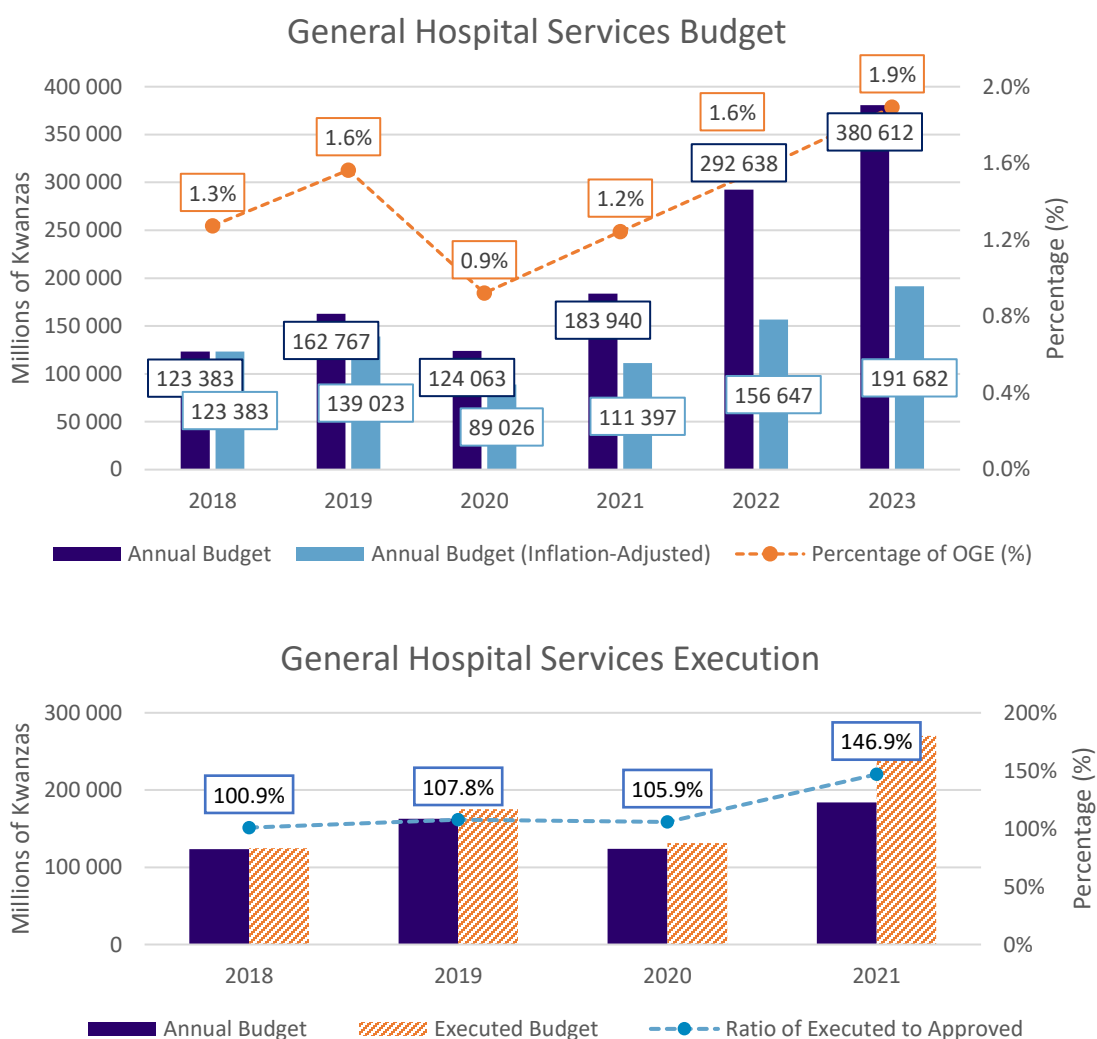


Figure 23. General Hospital Services budget and execution.

Source: OGE 2018 - 2023 and data by MINFIN.

The annual budget allocated towards these services has had a ratio of executed to approved budget above 100%. In 2021, the government spent an extra Kz 86 billion on top of the planned budget — which may have fueled the budget increase in 2022 and 2023.

Regarding the distribution of General Hospital Services funding, in 2022, it was divided between the Provincial Governments (58%) and MINSA (42%). The latter has been gaining a larger relevance in the previous two years, as opposed to the period between 2018 and 2020, where its representation was below 25%.

2.4.2. Specialized Hospital Services

Unlike General Services', the Specialized Hospital Services' budget has remained rather stagnant recently. There was a modest decrease in funding for these services between 2020 and 2022, which was reverted in 2023 (Figure 24). The percentage of the OGE represented by Specialized Hospital Services remained the same in 2023 as in 2022 (*i.e.*, 0.4%), which led to an increase in the nominal budget up to Kz 83 billion, due to a higher overall State budget.

There has been an excess in execution as of 2020, which has culminated in a ratio of executed to approved budget of 171% in 2021. This may be indicative of budget underestimation or budgetary overruns.

Specialized Hospital Services were much more centralized in MINSA (80%) in 2022, as opposed to General Hospital Services. The Provincial Governments represented only 20% of the services' budget. This has been the status since 2020.

Not all provinces have allocated funding for Specialized Hospital Services though, and, while for many the budget has been intermittent, the Provincial Government of Zaire has not allocated any funding for these services for the past 5 years.

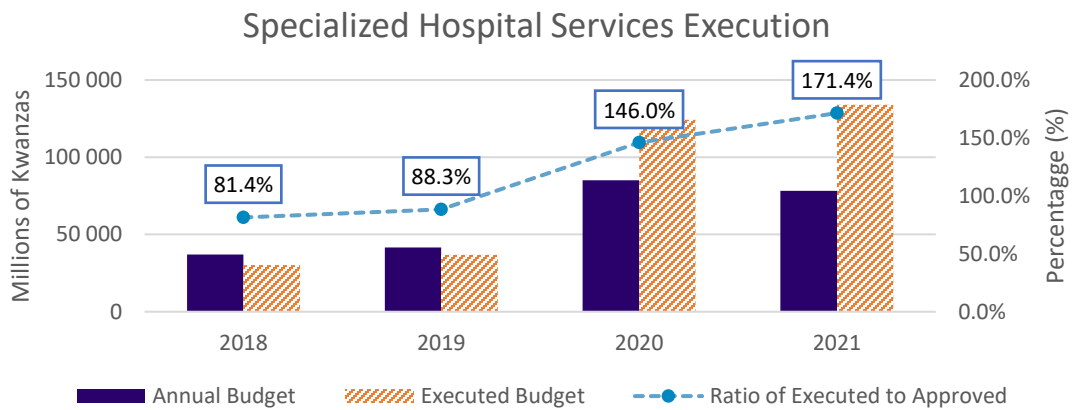
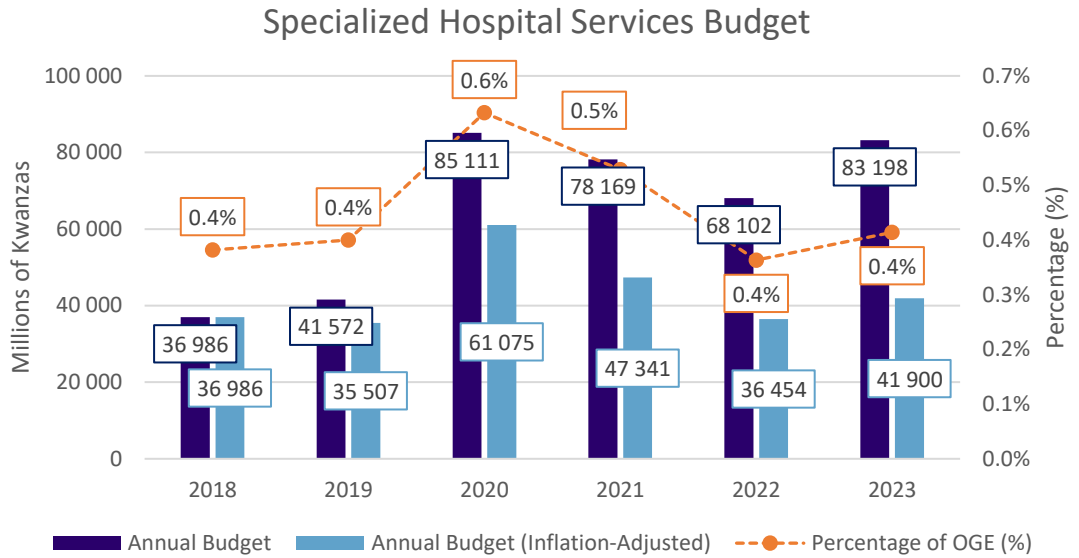


Figure 24. Specialized Hospital Services budget and execution.
Source: OGE 2018 - 2023 and data by MINFIN.

2.5. Program for the Improvement of Medical and Medication Assistance

2.5.1. Annual Budget and Execution

The program for the Improvement of Medical and Medication Assistance is by far the largest health development program in Angola. It was specifically designed to improve access by the population to basic health services and their respective quality. And is therefore the major tool behind the push towards Universal Health Coverage in Angola.

Its budget for 2023 is Kz 229 billion — a 33% increase from 2022 — and follows an increase for two-consecutive years. Regarding the budget's execution, the government reported that the executed budget was 135% and 254% of the approved budget in 2020 and 2021, respectively (Figure 25).

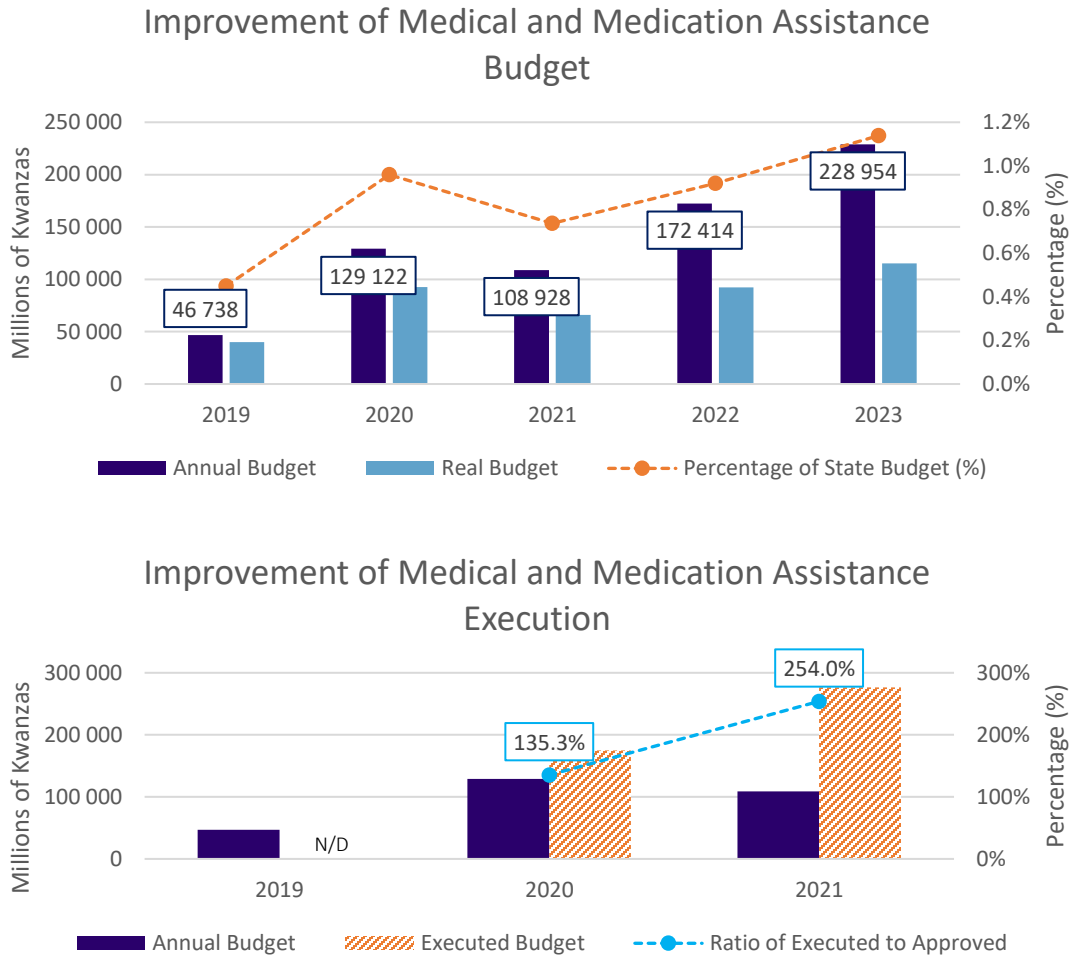


Figure 25. Improvement of Medical and Medication Assistance budget and execution.
Source: OGE 2018 - 2023 and CGE 2019 - 2021.

The increased approved budget and high executed budgets are in part a consequence of the spillover of expenditure associated with the prevention of COVID-19 — which was incorporated into this program as opposed to being inserted into the response against COVID-19, as discussed in Chapter 6.

In 2021, the government invested in the acquisition of essential medicines, vaccines, PCR test and rapid diagnosis tests — including for COVID-19, as well as new hospital

beds, Personal protective equipment (PPEs) and ventilators. It also elaborated and executed the National Vaccination Plan Against COVID-19.

2.5.2. Distribution

In 2022, the program for the Improvement of Medical and Medication Assistance was largely funded through MINSa (71%), with the Provincial Governments contributing to 19% of the program’s budget. A similar distribution was observed in the previous two years. The remaining budget is allocated to MINDENVP and MINIT — reinforcing the role of the central government (Figure 26).

While Luanda is the province with the largest bulk funding, it is again the one with the least funds per capita (Kz 466 per capita). The most funded provinces when adjusted for their populations (Figure 27) are Cuando-Cubango (Kz 5.0 thousand per capita), Bengo (Kz 3.6 thousand per capita) and Cabinda (Kz 3.2 thousand per capita).

It is possible that these differences are partly influenced by economies of scale. For example, delivering services to the population in Cuando-Cubango may be more costly by virtue of accessibility and transport costs than Luanda. Further research would be needed to effectively assess whether or not this is the case.

2.5.3. Performance Indicators

The Government of Angola has defined a number of performance indicators for each of its development programs in accordance with its National Development Plan 2018-2025. Reporting on these indicators is done in the General State Account (CGE), where the objectives and results are presented together.

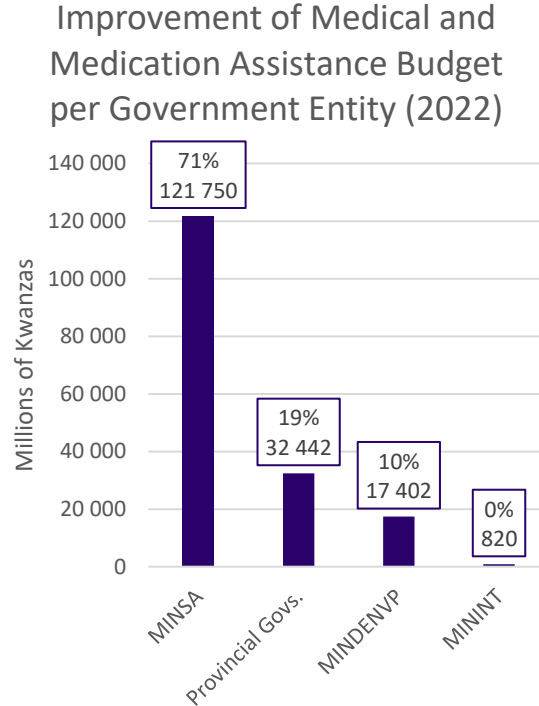


Figure 26. Improvement of Medical and Medication Assistance budget per Government Entity. Source: OGE 2022.

As of 2022, the government also began to disclose which performance indicators will guide the program in the General State Budget, at the beginning of the year. This is a commendable improvement in budget transparency, which allows the public to understand what the goals of each program in advance are, and then compare with the data published at the end of the year.

Not only did the Government disclose what are the performance indicators for each program, but it also presented the budget allocated to each indicator. This allows us to understand which indicators are being prioritized.

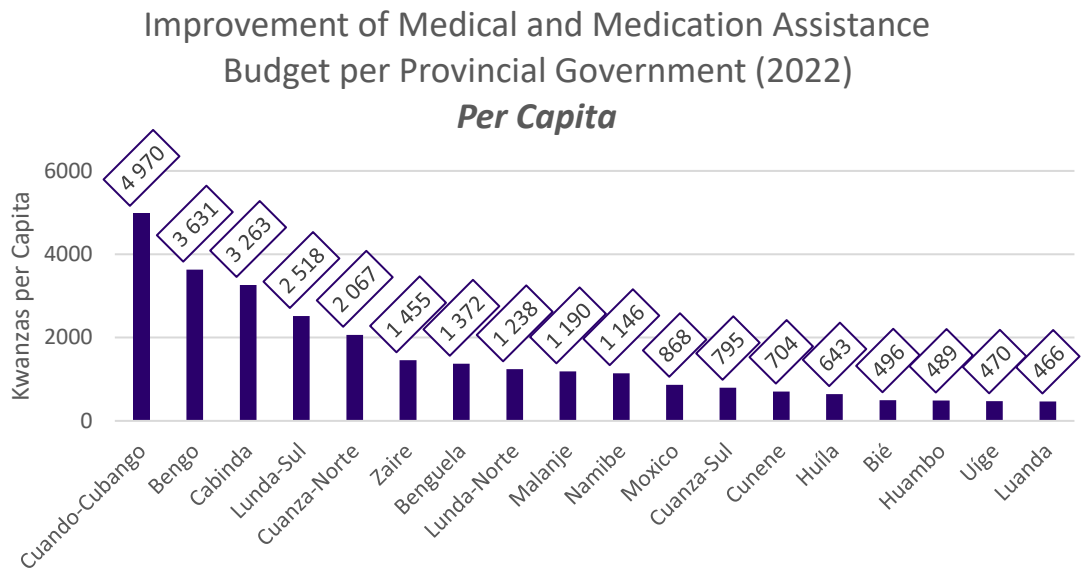


Figure 27. Improvement of Medical and Medication Assistance budget per Provincial Government. Source: OGE 2022.

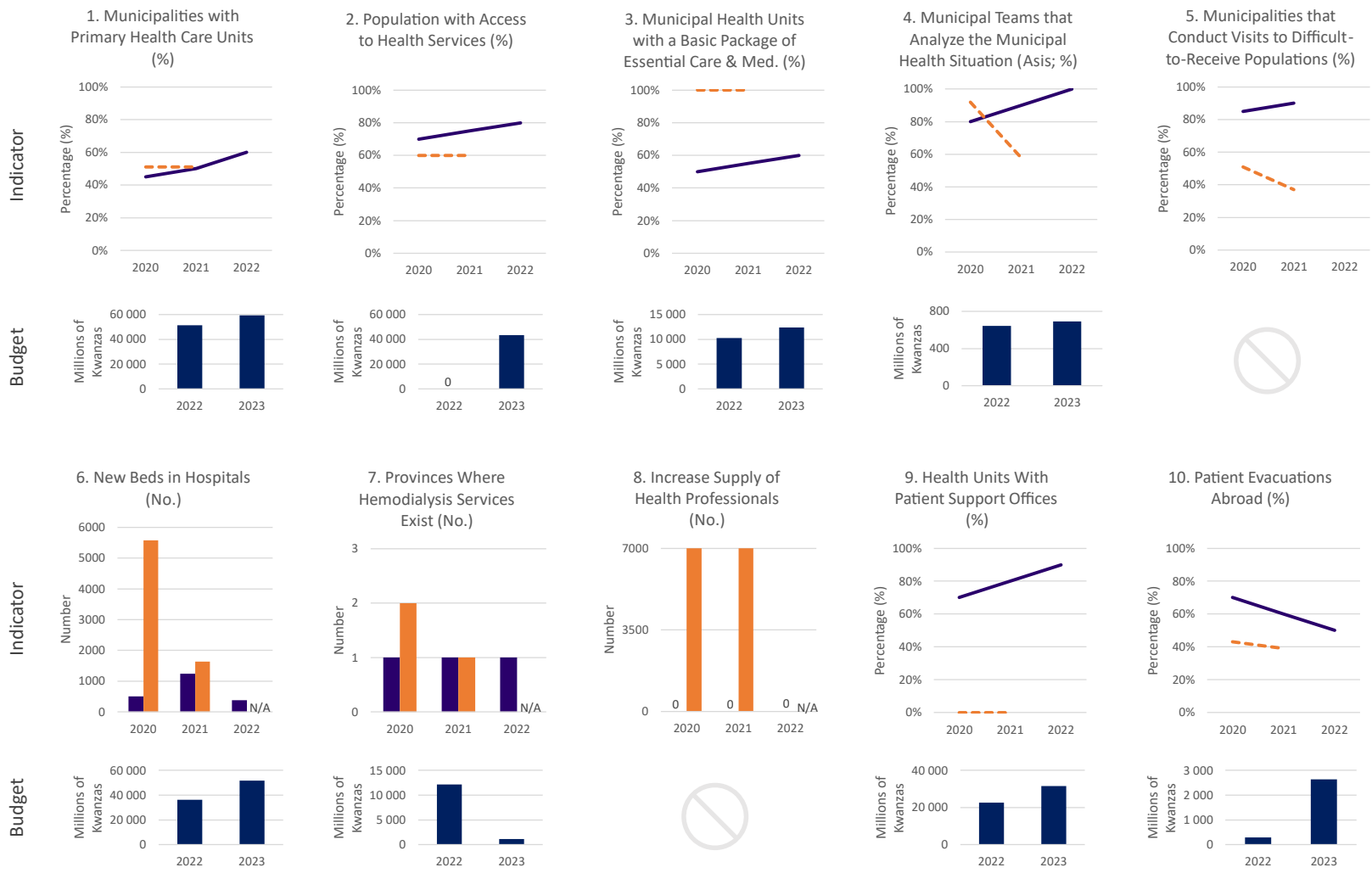
The following Figure 28 displays each of the 10 individual performance indicators, their objectives and results (2020-2022) and their planned budget for 2022 and 2023.

When considering the programs performance indicators reported in the CGE, only three out of ten indicators have actually been successful. The first successful indicator is the percentage of 'Municipal Health Units with a basic package of essential and medicines', which has been 100% since 2020 the second one is the 'number of hospital beds', which have been significantly above the planned targets; and the third one is the 'increase supply of health professionals'. Funding for the later indicator has ceased as of 2022.

There are two performance indicators declining contrary to the targets: 'the percentage of municipal teams that analyze the municipal health situation' and 'the ratio of municipalities that conduct visits to difficult-to-reach populations'. Funding for the later has also ceased in 2022. Meanwhile, the number of evacuations of patients abroad is also decreasing — partly due to COVID-19 restrictions and partly due to an increase in the number of specialized hospitals.

Also worthy of note is that funding for hemodialysis has significantly decreased in 2023.

Planned Objective ————— End-year Result - - - - -



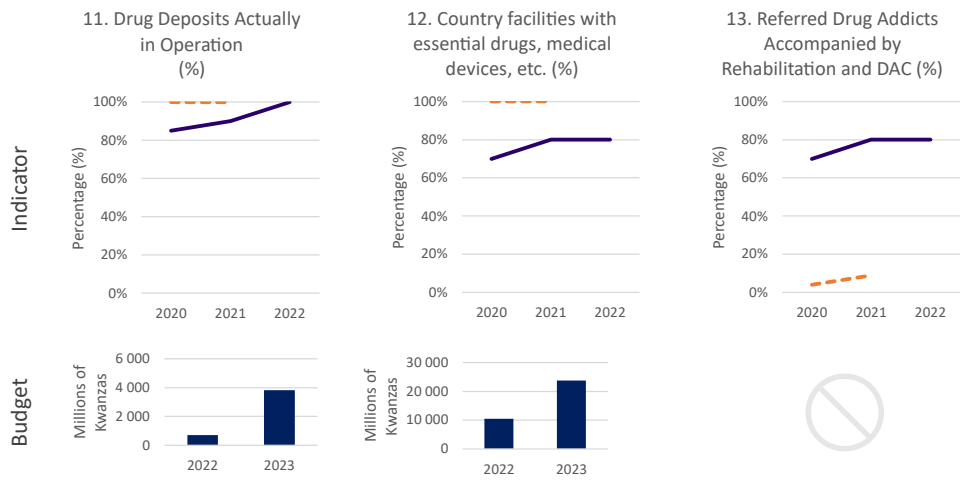


Figure 28. Improvement of Medical and Medication Assistance: Performance Indicators. Source: CGE 2018 – 2022, OGE 2022 – 2023.

Note: Performance indicator No. 7 likely refers to *new* provinces where hemodialysis exists, as this should be cumulative.

DAC: *Drug and Alcohol Clinics*

2.6. Program for Strengthening of the Health Information System

2.6.1. Brief Overview

The Program for Strengthening of the Health Information System and Health Research Development is the smallest program within the health budget. It launched with a budget of Kz 163.7 million in 2019 and peaked at Kz 7.1 billion in 2021. In 2022, its budget was Kz 1.0 billion (Figure 29).

The only data on execution publicly available pertains to 2020, where the executed budget was 57.3% of the approved budget — a total of Kz 518.7 million.

It has three main objectives:

- I. Develop the Digital Health Information System (DHIS2) by enrolling national health entities,
- II. Implement the Vid-R System in the Municipalities (na Epidemic Outbreak Reporting System),
- III. Promote scientific research (measured in number of scientific studies published in Angola).

In 2020 and 2021, the Government reported that 100% of health entities were enrolled in the DHIS2; 100% of Municipalities had implemented the Epidemic Outbreak Reporting System and that the number of studies published were 6 and 2, respectively.

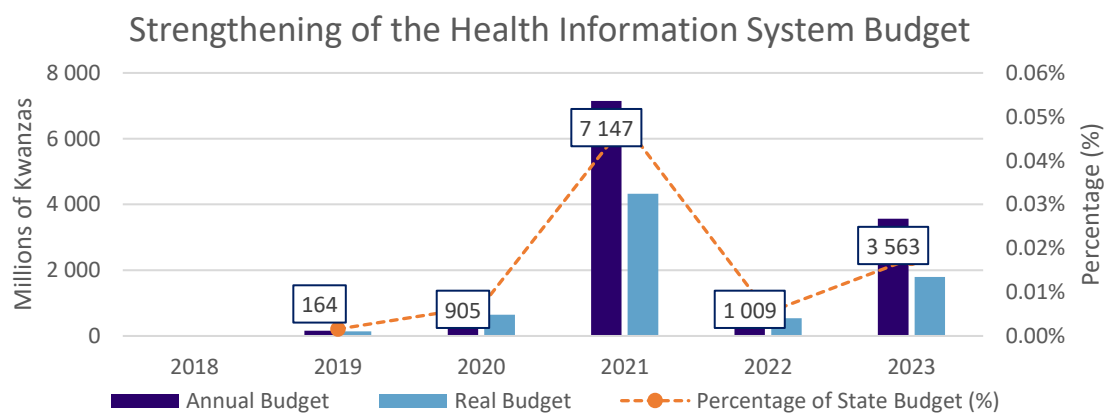


Figure 29. Strengthening of the Health Information System Budget. Source: OGE: 2018 – 2023.

3. Maternal and Child Health

3.1. The Medical and Maternity Centers Services

3.1.1. Annual Budget and Execution

The budget for Medical and Maternity Center Services declined by 45.5% between 2018 and 2021. It was then raised again in 2022 to a total of Kz 33.6 billion — an increase of 55.2%. When adjusted for inflation this decline becomes more accentuated, while the increase in 2022 loses significance (Figure 30).

Furthermore, executed budgets were low in those four years. The executed budget represented less than 50% of the approved budget in 2018. This ratio increased annually as the budget decreased (Figure 31).

In 2023, the Medical and Maternity Center Services budget more than doubled up to Kz 70.2 billion, with 1.7 p.p. increase in the percentage of OGE.

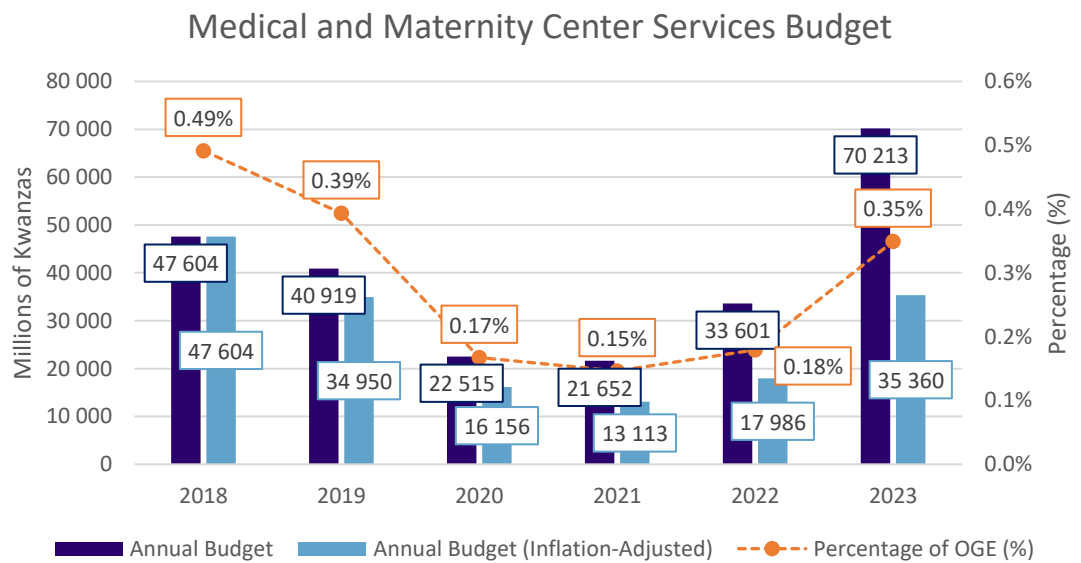


Figure 30. Medical and Maternity Centers Services Budget. Source: OGE: 2018 – 2023.

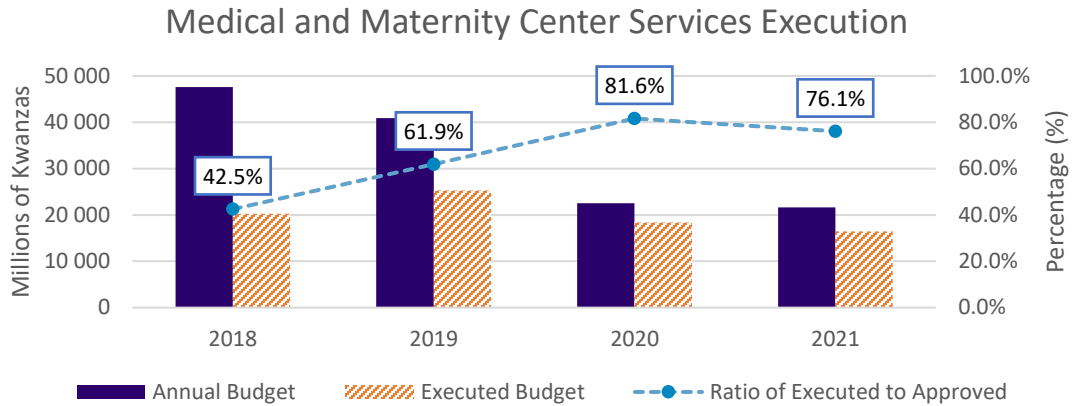
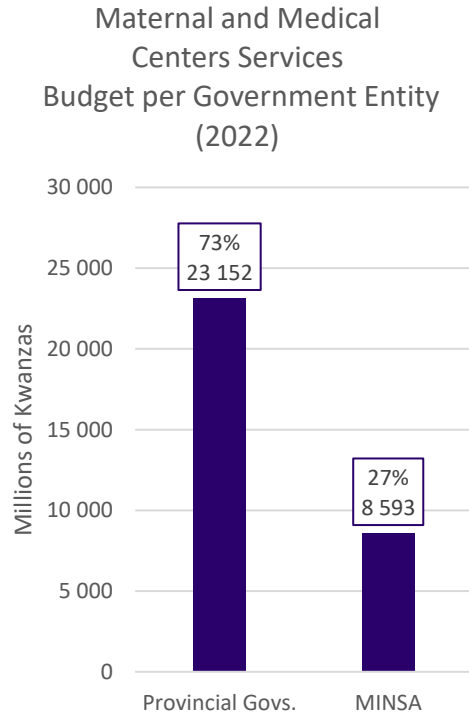


Figure 31. Medical and Maternity Centers Services Execution.
 Source: OGE 2018 – 2021 and data from MINFIN.

3.1.2. Distribution

Medical and Maternity Services are largely distributed amongst the provinces (73%), while roughly a quarter of that budget is allocated towards MINSAs (27%; Figure 32).



Within the provinces, Malanje, Huíla and Bié had the largest budget—in terms of absolute values. However, Lunda-Sul was the province with the highest budget per capita (Kz 3.0 thousand), followed by Namibe (Kz 2.7 thousand) and Bengo (Kz 2.6 thousand). Over half of the provinces allocated less than Kz 1 thousand, while Cuanza-Sul and Cunene did not allocate any funds to support these services (Figure 33).

Part of these services may be under the tutelage of Municipal Authorities and therefore not accounted for in the Provincial Government budget.

Figure 32. Medical and Maternity Centers Services Distribution.
 Source: OGE 2022.

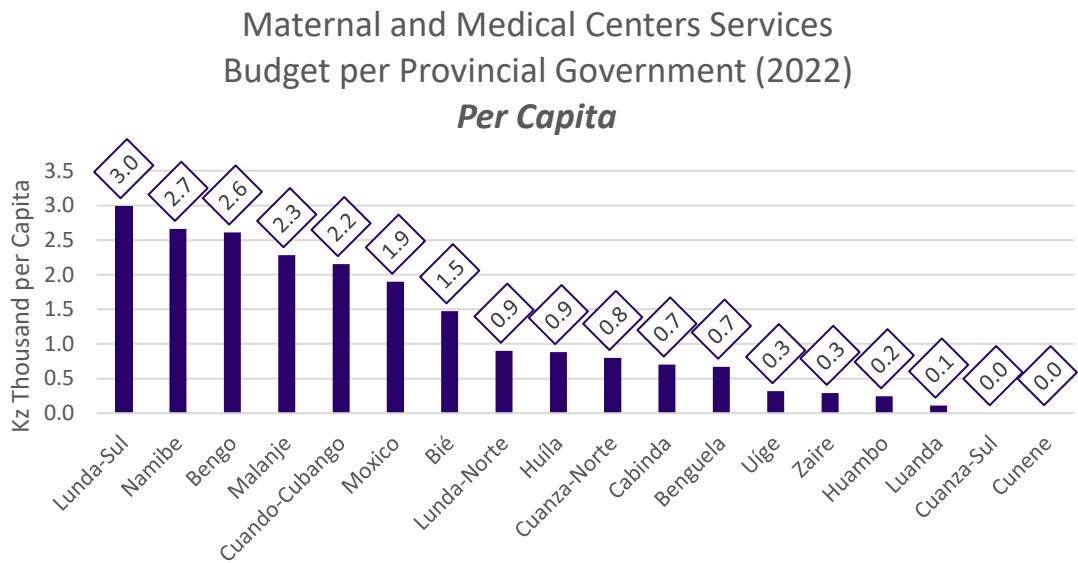


Figure 33. Medical and Maternity Centers Services per Provincial Government.
Source: OGE 2022.

3.2. Program for the Improvement of Maternal and Child Health and Nutrition

3.2.1. Annual Budget and Execution

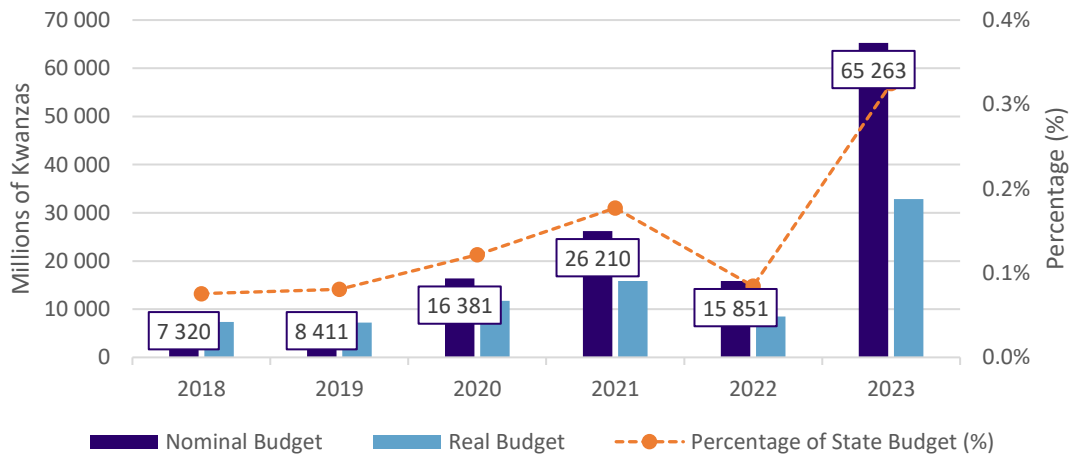
The Government of Angola has a long-running development program for the Improvement of Maternal and Child Health and Nutrition, concomitant to the budget allocated to Medical and Maternity Centers Services.

This is one of the most important programs within the health and nutrition sectors as it aims to respond to the challenges facing maternal, neonatal and juvenile health – core aspects of a good healthcare system. It is currently the second-most budget for health-related program and has been in place for the last decade – meaning that it was not affected by the general restructuring of programs observed between 2018 and 2019.

The program’s budget has been growing overall for the past five years, with the exception of 2022 — where it declined in comparison to 2021 (Figure 34). This is opposite to the decline observed in the budget for the Medical and Maternity Centers Services between 2018 and 2021. However, its executed budget is not consistent.

While the budget grew from 2018 to 2019 by roughly Kz 1 billion, the execution of the planned funds in 2019 was 41.6% which effectively left the program with half of the investment as compared to 2018. In 2020, the ratio of executed to approved budget reported in the CGE was less 1%. We were unable to determine the reason behind this discrepancy.

Improvement of Maternal and Child Health and Nutrition Budget



Improvement of Maternal and Child Health and Nutrition Execution

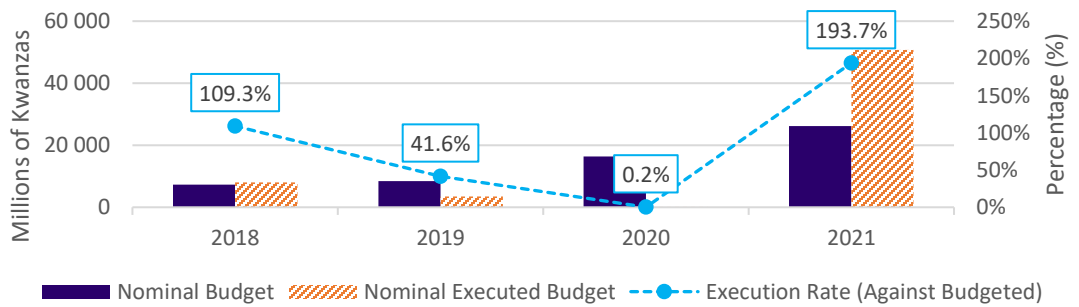


Figure 34. Improvement of Maternal and Child Health and Nutrition Budget and Execution. Source: OGE 2018 – 2023 and CGE 2018 – 2021.

In 2021, the Government executed nearly double the budget initially approved for the program, effectively disbursing Kz 50.7 billion Kz. Three times the budget of the Medical and Maternity Centers Services. Part of the expenditure was used to

strengthen institutional capacity by investing in human capital — namely within primary health care — with the specialization of 576 doctors in family health.

Furthermore, the government invested that year in the Maternal and Child Centers of Moxico — rehabilitation, Luquembo (Malanje) and Tanque-Belas (Luanda) — both construction and equipping, as well as in the construction and equipping of the Pediatric Hospital of Huambo.

Lastly, the Government also elaborated the National Multisectoral Nutrition Plan in 2021.

3.2.2. Distribution

In 2022, the program was largely concentrated in MINSA (83%), with the remaining budget being distributed among the Provincial Governments (17%; Figure 35).

Of the provinces, Lunda-Sul had the highest budget in 2022 (Kz 435 per capita), followed by Bié (Kz 411 per capita) and Malanje (Kz 281 per capita). On the opposite end of the spectrum Huambo allocated Kz 19 per capita (Figure 36). The budget of each province seems to fluctuate between 2018 and 2022 – possibly depending on the projects being implemented.

Meanwhile, there were 8 provinces without any funding for this program in 2022. Of these 8 provinces, Cabinda, Zaire and Namibe have not allocated any funding for this program for the past 5 years.

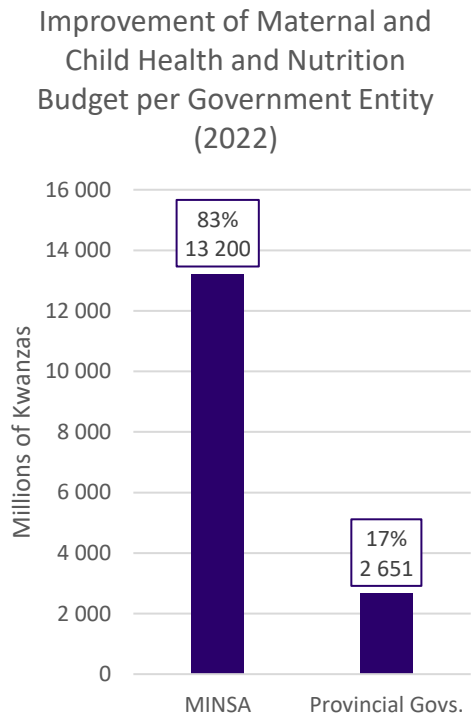


Figure 35. Improvement of Maternal and Child Health and Nutrition Budget per Government Entity.

Source: OGE 2022.

Improvement of Maternal and Child Health and Nutrition Budget per per Provincial Government (2022)

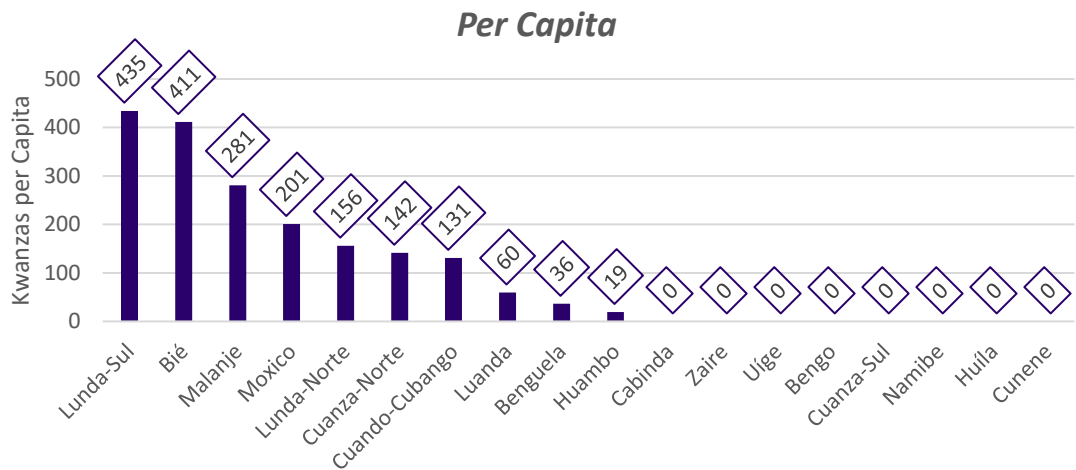


Figure 36. Improvement of Maternal and Child Health and Nutrition Budget per Provincial Government. Source: OGE 2022.

3.2.3. Performance Indicators

Summary of Findings:

- 3/10 indicators either met or went beyond their objectives in 2021.
- The goals of each indicator are not defined based on the results obtained in the previous year.
- There has been a downsizing on the number of indicators in 2022.

As one of the oldest programs, the Improvement of Maternal and Child Health and Nutrition is one of the most detailed programs with clearly defined indicators, planned objectives of success for each year and a consistent reporting of the annual results achieved (Figure 37). One thing that becomes clear, when analyzing the performance indicators reported, is the fact that objectives for a given year are defined independently of the results of the previous year.

A good example of this is the institutional maternal mortality rate. In 2019, Angola registered 170 deaths per 100 000 live births. This was below the planned objective of 219 deaths, and a positive sign of improved maternal health. However, the purported

objective for 2020 was a ratio of 213 death. Meaning that instead of lowering the mortality ratio, the purpose was to raise it.

This is obviously not the intent of the program; however, it shows that the objectives for the program are calculated for the long-term and not adjusted based on the results of the previous year. A second example here would be the percentage of municipalities with integrated adolescent care services, whose objective for 2021 was below the results reached in 2020. More examples can be identified in other programs.

Another interesting observation is that between 2021 and 2022, the government reduced the number of indicators of several programs including this one. In this case, the immunization coverage against measles⁴⁵ (see Chapter 4.3.) and the percentage of children under-five receiving vitamin A supplementation have both been removed as performance indicators of the program. Despite the fact that the results reported for both these indicators in 2021 falling short of the initially planned objectives.

⁴⁵ Immunization coverage will be further discussed in Chapter 6.

Planned Objective

End-year Result

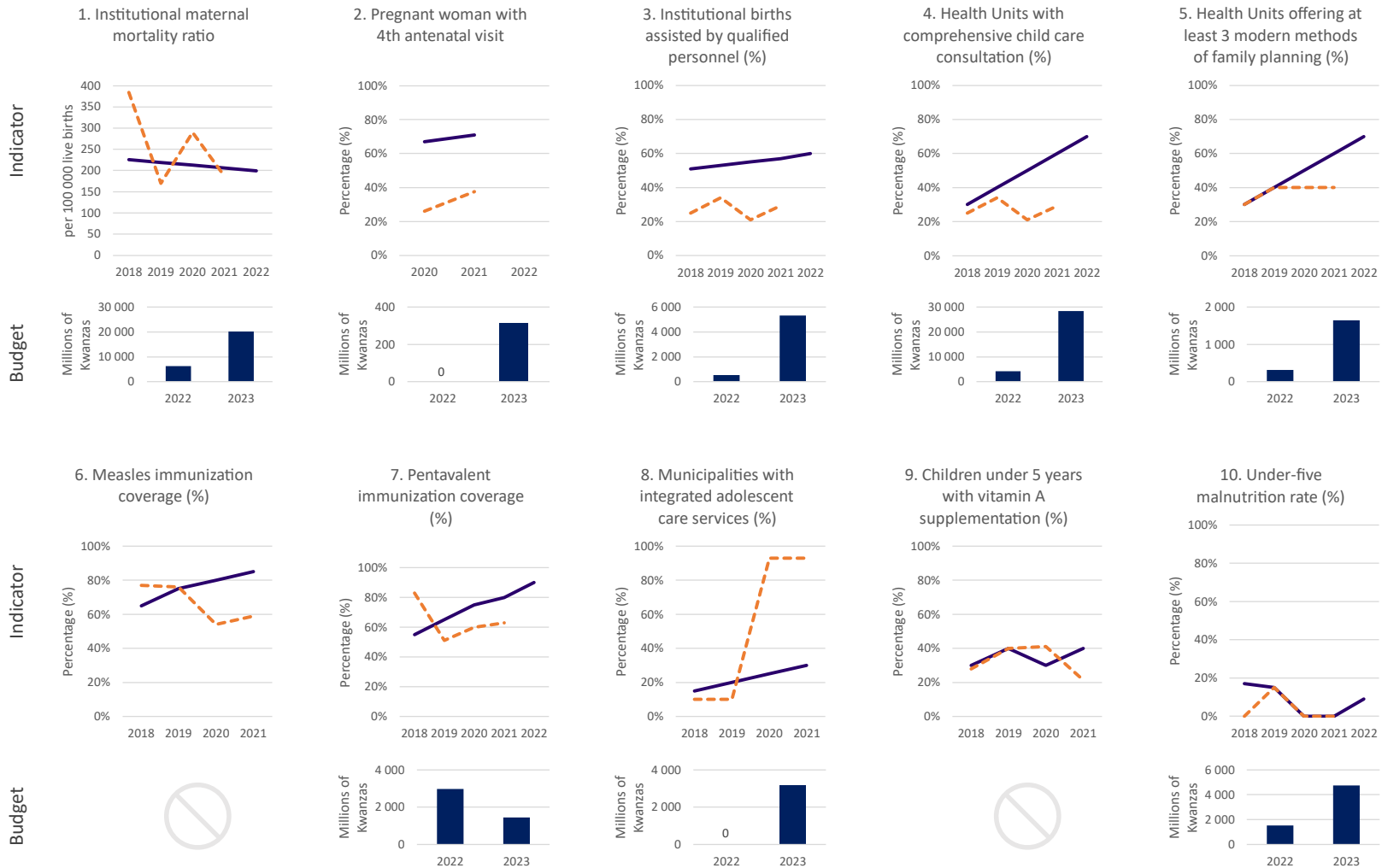


Figure 37. Improvement of Maternal and Child Health and Nutrition: Performance Indicators.

Source: CGE 2018 – 2022, OGE 2022 – 2023.

Several of these performance indicators were surveyed in the IIMS 2016 and can be compared to the 2022 budget of the Program for the Improvement of Maternal and Child Health and Nutrition. The budget per province per capita does not seem to reflect under-five mortality rates, the percentage of women who received at least antenatal consultations by qualified personnel nor the percentage of assisted births per province (Figure 38).

It is difficult to establish a correlation given that there is a lack of recent data on the performance indicators per province. However, if we assume that the data from 2016 has not changed significantly, funding is generally not flowing to the most affected provinces — especially Cuanza-Sul and Huíla.

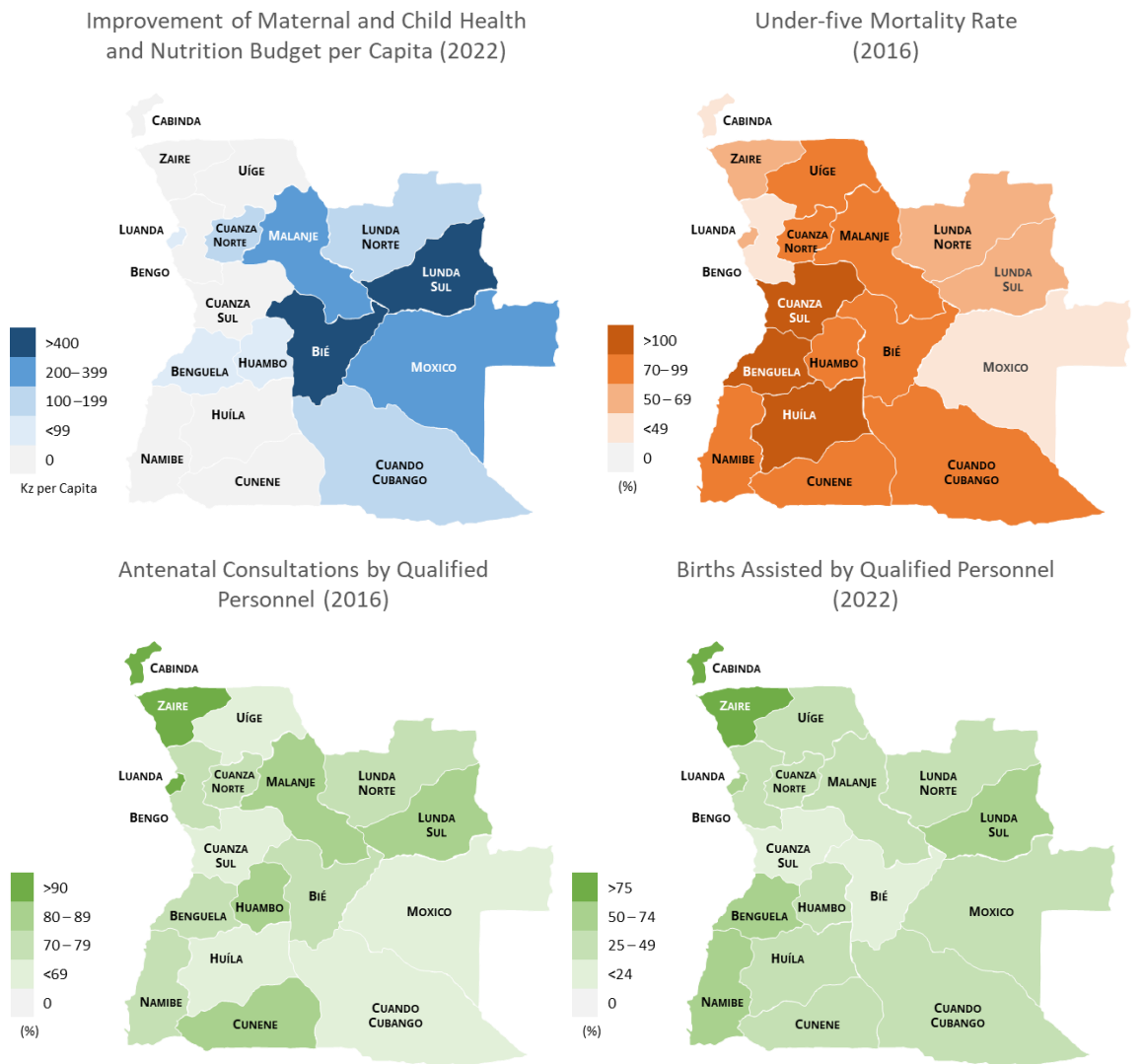


Figure 38. Program for the Improvement of Maternal and Child Health and Nutrition Budget per Capita vs. the outcome of its performance indicators — choropleth map of Angola. Source: OGE 2022 and IIMS 2016

3.3. A Closer Look at Maternal and Child Health and Nutrition Challenges

3.3.1. Malnutrition

Angola's nutritional targets are not aligned with international WHO/UNICEF recommendations.

Malnutrition results from a deficiency, excess or imbalance in energy and/or nutrients' intake, encompassing three broad groups of conditions: i) undernutrition (wasting, stunting and underweight); ii) micronutrient-related malnutrition (micronutrient deficiencies or excesses); and iii) overweight, obesity and diet-related noncommunicable diseases⁴⁶.

As showed in Chapter 2.1., Angola is far from achieving the WHO Global Nutrition Targets 2025⁴⁷ and the WHO/UNICEF Extension of the 2025 Maternal, Infant and Young Child Nutrition Targets to 2030⁴⁸. Those recommended targets include the following indicators: i) women of reproductive age with anemia, ii) low birth weight, iii) exclusive breastfeeding in the first 6 months, as well as iv) under-five stunting, wasting and overweight.

The latest Angolan nutrition targets to which we had access were defined on the PDN 2018-2022⁴⁹, being that i) exclusive breastfeeding in the first 6 months, ii) coverage of vitamin A supplementation (VAS) in children aged 6-59 months and iii) under-five underweight were the chosen indicators to monitor. The last two are represented in the State Budget through the program for the Improvement of Maternal and Child Health and Nutrition, but not the first one.

The Angolan nutritional targets, therefore, do not seem be in line with international recommendations previously described.

Regarding micronutrient supplementation, evidence has demonstrated that VAS results in a clinically meaningful reduction in morbidity and mortality in children from six months to five years of age⁵⁰. For that reason, the inclusion of its coverage as an indicator is particularly relevant in the context of Angola. However, our analysis found that VAS was not considered as a performance indicator in 2022 nor will it be in 2023.

Regarding undernutrition indicators, it is important to highlight that an underweight child may be stunted, wasted or both. Hence, the choice to monitor underweight alone

⁴⁶ WHO, [Malnutrition Fact Sheet](#)

⁴⁷ WHO, [Global nutrition targets 2025: policy brief series](#) (2014)

⁴⁸ WHO/UNICEF, [The extension of the 2025 maternal, infant and young child nutrition targets to 2030](#) (2019)

⁴⁹ [Plano de Desenvolvimento Nacional 2018 - 2022](#)

⁵⁰ Imdad, et al. [Vitamin A supplementation for preventing morbidity and mortality in children from six months to five years of age](#) (2022)

without considering simultaneously the other two undernutrition indicators (stunting and wasting) is very limiting.

3.3.2. Diarrheal Diseases

According to the IIMS 2016, the prevalence of diarrhea in children under 5 years of age is 15.6% in Angola. Slightly higher in urban areas (16.1%) than in rural areas (14.8%), and particularly prevalent between 6 and 23 months (27%).

It is also more prevalent in children who do not have access to basic sanitation, which highlights the importance of investing in sanitation infrastructures in order to prevent diarrhea. A report by UNICEF on the Water, Sanitation and Hygiene (WASH) sector in Angola will be published (back to back with this report) identifying the current bottlenecks within the sector and proposing several recommendations to further advance it. In that report, the WASH budget for 2022 was estimated to be Kz 370.8 billion — representing 2.0% of the OGE.

Specific investment in basic sanitation on behalf of the Government (Kz 102 billion as of 2023) has been increasing for the past five years, which shows a recent prioritization of the sector.

Access to clean water and hygiene practices are further drivers of diarrhea prevalence alongside basic sanitation.

According to Gasparinho et al. (2016)⁵¹, the leading causes of diarrhea in the Bengo province are the following enteric pathogens: *Cryptosporidium* protozoa (30.0%), rotavirus (25.1%) *Giardia lamblia* protozoa (21.6%), diarrheagenic *Escherichia coli* bacteria (6.3%), *Ascaris lumbricoides* (4.1%), adenovirus (3.8%), *Strongyloides stercoralis* (3.5%), astrovirus (2.6%), *Hymenolepis nana* (1.7%) and others (1.3%). This data can be generally extrapolated to Angola and is consistent with studies in other provinces.

In the study, at least one pathogenic agent was isolated in 66.6% of the samples, which supports the importance of infectious causes of diarrheal disease in children younger than 5 years in this region of Angola. This percentage was higher compared with that obtained in a Mozambican hospital-based study (42.2%) but similar to a study conducted in Tanzania (67.1%).

Rotavirus infections are particularly dangerous due to their increased prevalence in children younger than 12 months, and association with vomiting and wasting. As can be seen in Chapter 4, rotavirus immunization is part of Angola's National Vaccination Calendar and the immunization coverage according to the Government is 55%.

⁵¹ to Gasparinho et al. (2016), The Pediatric Infectious Disease Journal

4. The National Vaccination Calendar

4.1. The National Vaccination Calendar

Angola's National Vaccination Calendar covers all of the recommended routine immunizations *in all children* by the WHO⁵² (Table 4), with one exception: the immunization against the Human Papilloma Virus (HPV), currently recommended for girls between 9 and 14 years old.

Table 4. Angola's National Vaccination Calendar (2018).⁵³

Age	Vaccine	Dose	Administration Route
At birth	Polio	Dose 0	Oral
	BCG	Single Dose	Intradermal
	Hepatitis B	Single Dose	Intramuscular
2 Months	Polio	1 st Dose	Oral
	Rotavirus	1 st Dose	Oral — Sublingual
	Pneumococcus	1 st Dose	Intramuscular
	Pentavalent	1 st Dose	Intramuscular
4 Months	Polio	2 nd Dose	Oral
	Rotavirus	2 nd Dose	Oral — Sublingual
	Inactivated Polio	Single Dose	Intramuscular
	Pneumococcus	2 nd Dose	Intramuscular
	Pentavalent	2 nd Dose	Intramuscular
6 Months	Polio	3 rd Dose	Oral
	Vitamin A	1 st Dose	Oral
	Pneumococcus	3 rd Dose	Intramuscular
	Pentavalent	3 rd Dose	Intramuscular
9 Months	Vitamin A	2 nd Dose	Oral
	Measles and Rubella	1 st Dose	Subcutaneous
	Yellow Fever	Single Dose	Subcutaneous
15 Months	Measles and Rubella	2 nd Dose	Subcutaneous

⁵² [WHO recommendations for routine immunization](#) (as of November 2021).

⁵³ [Manual do Mobilizador Social](#) (2018).

4.2. Routine Immunization: Budget and Coverage

According to data published by the WHO/ UNICEF Joint Reporting Form on Immunization⁵⁴, **in 2021, the Government of Angola spent US\$ 28.7 million (Kz18.3 billion) on routine immunization** — the equivalent to 4.8% of the executed budget for Public Health Services (see Chapter 5.1.). Sixty percent of that was directed to the purchase of vaccines. Government spending represented 93% of total expenditure on routine immunization in 2021, which amounted to a total of US\$ 31.0 million (Kz 19.7 billion) when adding the funds from external sources —the highest since 2018.

If we consider that an estimate of 1.07 million infants born Angola in 2021 survived (past one-year of age), **Angola's total expenditure on routine immunization amounted to US\$ 28.9 per surviving infant (Kz18.4 thousand)** that year.

For comparison, the WHO African region spent on average, between 2018 and 2020, US\$ 41 per surviving infant⁵⁵, while globally US\$ 68 were spent. It is important to note though, that Angola is fully supporting its immunization since transitioned from GAVI support.

These numbers reflect the magnitude of the challenge that Angola has to face in order to immunize its growing population, but also that there is a great need for higher investment in the routine immunization of children.

⁵⁴ [WHO/ UNICEF Joint Reporting Form on Immunization](#)

⁵⁵ WHO, [Situation Analysis of Immunization Expenditure — Key Facts](#) (2021).



Immunization Coverage in Angola (2012 - 2021)



Figure 40. Immunization coverage in Angola. Source: WHO Immunization Dashboard⁵⁶. Note: Measle’s immunization coverage refers to the 2nd dose.

⁵⁶ [WHO Immunization Dashboard](#)

According to government data provided to the WHO, for the past ten years, general immunization coverage in Angola either follows or is above the average estimated coverage for the WHO African region (Figure 40)⁵⁷.

As of 2021, the highest coverage concerns immunization with the Bacillus Calmette–Guérin (BCG) vaccine — against tuberculosis — at 74%; and the lowest coverage is that of immunization against measles at 40%.

However, official reporting is in most cases above the estimated coverage calculated by WHO and UNICEF⁵⁸. The later most accurately reflects the data collected by the latest National Health Indicators Survey of 2016⁵⁹. The one exception being the immunization against measles, where the estimate appears to match the official reports. If we consider the WHO/ UNICEF estimates, coverage in Angola is typically below average by roughly 20 p.p.

Immunization coverage in Angola has seen a general decline since 2018-2019, for multiple vaccines, which was further aggravated by the COVID-19 pandemic in 2020.

This has been the case for immunization against poliomyelitis (polio) with a third vaccine dose, where there is a decline since 2018, aggravated in 2021 — down to 64% coverage. Polio is a viral infectious disease that can cause permanent flaccid muscle paralysis, mostly affecting children under the age of five. Although wild-poliovirus has been officially eliminated in the WHO African Region as of 2020⁶⁰, thanks to the Global Polio Eradication Initiative⁶¹, Africa still has to contend with imported cases — like what happened in Mozambique and Malawi last year⁶² — and with vaccine-derived poliovirus infections. These are a consequence of the use of the oral polio vaccine (OPV), which contains an attenuated strain of the virus.

In the case of Angola, the most recent outbreak was reported in 2019⁶³, which highlights the continued importance of this vaccine.

A similar trend is observed for the remaining vaccines, including the pentavalent vaccine administered in Angola, also known as the 5-in-1 vaccine, which immunizes against Hepatitis B (HepB), Diphtheria, Tetanus toxoid and Pertussis (DTP), and *Haemophilus influenzae* B (Hib) — thus, covering three indicators in Figure 40.

The vaccines with an overall larger coverage are those administered earlier in the child's development, a phenomenon that follows a worldwide pattern.

⁵⁷ All African countries except for Morocco, Tunisia, Libya, Egypt, Sudan, South Sudan, Somalia and Djibouti

⁵⁸ To understand how these estimates are calculated please refer to the WHO Immunization Dashboard.

⁵⁹ Inquérito dos Indicadores Múltiplos de Saúde (IIMS; 2016).

⁶⁰ *The Guardian*, [Africa declared free of wild polio after decades of work](#) (2020).

⁶¹ [Global Polio Eradication Initiative](#)

⁶² WHO, [First polio outbreak in 30 years declared in Mozambique](#) (2022)

⁶³ WHO, [WHO supports Angola's Government efforts to end polio outbreak](#) (2019).

4.3. A Closer Look at Diseases Preventable Via Immunization

4.3.1. Measles and Rubella

Measles and Rubella are both vaccine-preventable highly contagious viral infection, which continue to affect the lives of children in Angola. Immunization against both of these diseases is foreseen in National Vaccination Calendar, however, the implementation of the calendar has not been entirely successful.

Immunization against measles has continuously failed to cover more than half of the children eligible for vaccination in Angola. This situation was further aggravated by the negative impact that the COVID-19 on routine immunization and health services in general all across Africa⁶⁴. Angola saw a drop in immunization coverage against measles of roughly 12 p.p. between 2019 and 2021 — concerning the 2nd dose.

Although reported cases declined between that period (Figure 41), it is expected that the numbers for 2022 are significantly higher given the measles outbreaks that occurred in 8 provinces last year — Bengo, Benguela, Bié, Cabinda, Cuanza-Norte, Cuanza-Sul, Uíge and Zaire⁶⁵. In response to these outbreaks, MINSA launched an integrated vaccination campaign against measles, rubella and polio, between July and August, with the support of multiple strategic partners (including UNICEF).

As a result, officials reported that a total of 1.5 million children younger than 5 years old were vaccinated — amounting to an immunization coverage of 92%. The campaign was later expanded to the remaining provinces between November and December. Hopefully, this will be enough to contain outbreaks in the years to come.

It cannot go unnoticed that a coverage above 90% in any province would strongly contrast with the data reported until 2021. It is also important to mention that data on immunization against measles reported by the Government to the WHO (for example, 40% in 2021) is not consistent with the data that is published in the CGE 2021 for the program for the Improvement of Maternal and Child Health and Nutrition (60% in 2021). Furthermore, neither of these numbers match the estimates of the WHO/UNICEF — which means that there are effectively three different values for the same parameter.

The immunization coverage against Rubella shows an even larger discrepancy between the official data (65% in 2021) and WHO/UNICEF estimates (below 36%). Rubella coverage is identical to the immunization coverage of the 1st dose of measles-containing vaccines, given that the two are taken together.

⁶⁴ Reuters, [COVID disrupted measles vaccinations in Africa and now cases are surging](#) (2022)

⁶⁵ WHO, [Angola Realiza Campanha Integrada contra Sarampo](#) (2022)

The case incidence for both measles and rubella has been consistently below the African average according to the WHO (Figure 41).

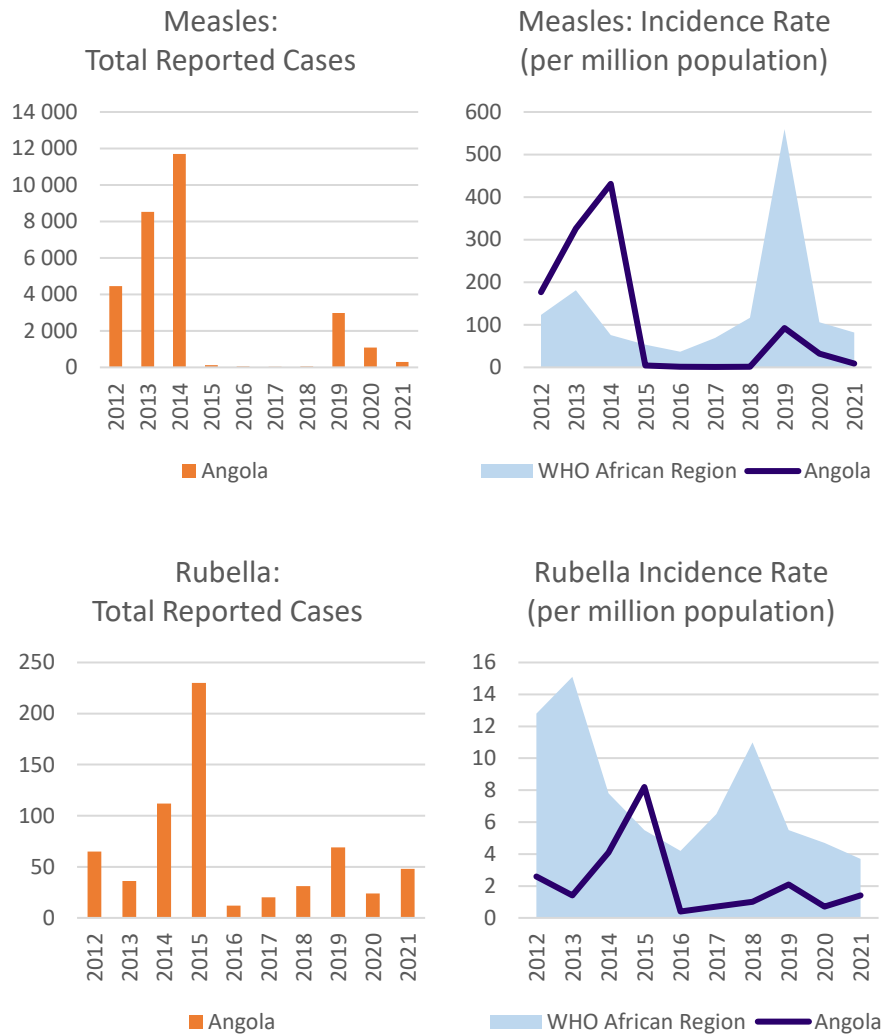


Figure 41. Measles and Rubella total reported cases and incidence rates.

Source: WHO Immunization Dashboard.

4.3.2. Diphtheria, Tetanus and Pertussis

The pentavalent vaccine administered in Angola contains antigens that immunize against the pathogens responsible for diphtheria (*Corynebacterium diphtheriae*), tetanus (*Clostridium tetani*) and pertussis (*Bordetella pertussis*) — also known as whooping cough.

Data on reported cases of diphtheria is not available through the WHO Immunization Dashboard and, according to the platform, Angola consistently registered zero cases

of pertussis between 2018 and 2021. Meanwhile, tetanus continues to be a major challenge with the country reporting 885 cases in 2021.

This corresponds to an incidence rate of 25.6 cases per million people, which is 9 times higher than the WHO African Region incidence (Figure 42).

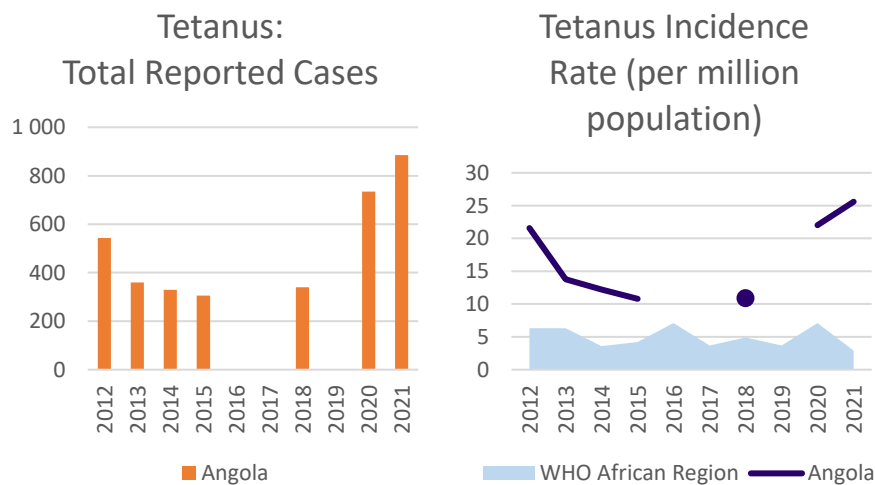


Figure 42. Tetanus total reported cases and incidence rate.

Source: WHO Immunization Dashboard.

4.3.3. Hepatitis B

Hepatitis B has been generally neglected in Africa, as health efforts have focused primarily on Malaria, Tuberculosis and HIV/ AIDS. However, it is one of the main causes of liver cirrhosis and hepatocellular carcinoma. It gained more attention in recent years following the launch of the WHO’s global strategy on viral hepatitis 2016 – 2021⁶⁶, in 2016. The goal of the strategy is to eliminate the disease as a major public health threat by 2030 and is in accordance with the SDG 3.3. which aims to combat hepatitis.

In Angola, the National Institute for the Fight against AIDS is also responsible for coordinating the national response to viral hepatitis. In 2015, the vaccine against hepatitis B was introduced in Angola’s Immunization Program⁶⁷, including a monovalent vaccine (within 24 hours of birth), followed by three pentavalent vaccine doses at two, four and six months of age. However, adequate coverage is yet to be achieved as seen in Chapter 4.2. Despite that, the budget allocated for 2023 towards

⁶⁶ WHO, [Global health sector strategy on viral hepatitis 2016-2021](#) (2016)

⁶⁷ WHO, [Angola: Government and partners launch free Hepatitis B Vaccine as an act of social justice and health equity](#) (2015)

achieving a higher pentavalent immunization coverage (as part of the program for the Improvement of Maternal and Child Health and Nutrition) decreased, when compared to 2022 (Chapter 3.2., Figure 37).

Screening for Hepatitis B Virus (HBV) is also limited; according to a study conducted in Lubango, between 2016 and 2017, only 44.6% of pregnant woman were screened for HBV⁶⁸. Screening rates are higher in urban areas versus rural areas, underscoring the urban-rural discrepancy in health service availability.

None of those who tested positive for HBV referred having initiated treatment, which was to be expected. Hepatitis B treatment was implemented in the Angolan National Health System (NHS) as of 2021, but only in the Luanda province at first. It has expanded in Benguela last year and is expected to launch in Huíla soon.

The prevalence of HBV infection in pregnant woman in Luanda, was recently estimated to be 25.7%⁶⁹. This is far from the lower threshold of what is considered a high prevalence of HBV (>8%)⁷⁰ and highlights the growing need to invest in immunization and treatment. It is not possible to know what the current trend in prevalence is, considering impaired screening capacity — in part due to low availability of tests. Furthermore, Hepatitis B prevalence was not covered in the IIMS 2016.

⁶⁸ Oliveira et al. [HIV, HBV and syphilis screening in antenatal care in Lubango, Angola](#), *BMJ Journals, Sexually Transmitted Infections* (2020)

⁶⁹ Vueba et al. [Prevalence of HIV and hepatitis B virus among pregnant women in Luanda \(Angola\): geospatial distribution and its association with socio-demographic and clinical-obstetric determinants](#) *BMC, Virology Journal* (2021)

⁷⁰ Nguyen et al. [Hepatitis B Virus: Advances in Prevention, Diagnosis, and Therapy](#) *ASM Journals, Clinical Microbiology Reviews* (2020)

5. The Battle Against Endemic Diseases

5.1. The Public Health Services

5.1.1. Annual Budget and Execution

As seen in Chapter 2.2., **Public Health Services have been highly prioritized within health sector for the past decade**, superseding General Health Services as the most funded component of the sector. The budget for 2023 is of Kz 798.1 billion, which represents nearly 4.0% of the OGE. This is a 58% increase in the budget as compared with last year — thus reverting the downward trend observed between 2020 and 2022 (Figure 43).

The execution of the approved budget has been historically low though. It peaked in 2021 at a ratio of executed to approved of 67.6%. This is significantly higher than the ratio of 28.3% observed in 2019 and an overall improvement.

It is important to note, though, that the Government of Angola has allocated funds to combating the ongoing COVID-19 pandemic in the country since 2020 — apart from the budget allocated to public health services (see Chapter 6).

5.1.2. Distribution

In 2022, the Public Health Services budget was heavily concentrated in the State Reserves (48%). These were followed by the Provincial Governments (27%) and MINSA (18%), in second and third place respectively. The remaining government entities had of total of 7% of the budget (Figure 44).

Within the Provincial Governments, Bengo, Cuanza-Norte and Cuando-Cubango were the three provinces with the highest budget per capita — similarly, to the distribution per province of the overall health budget.

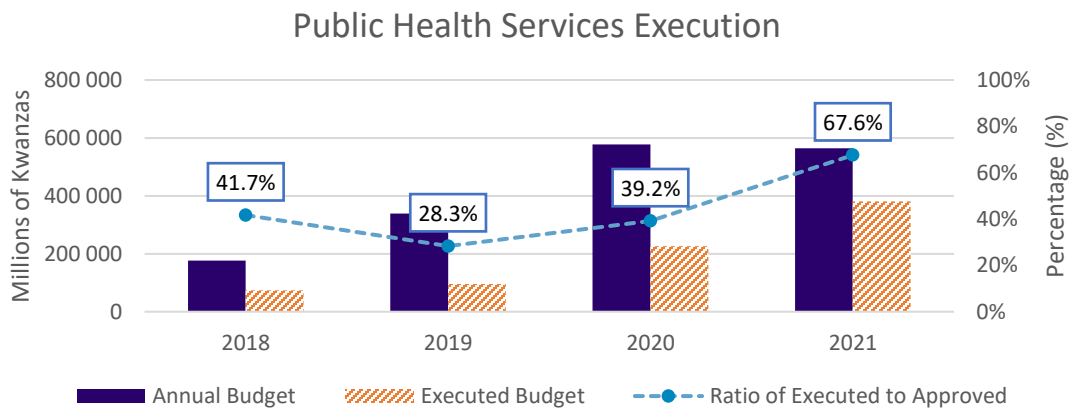
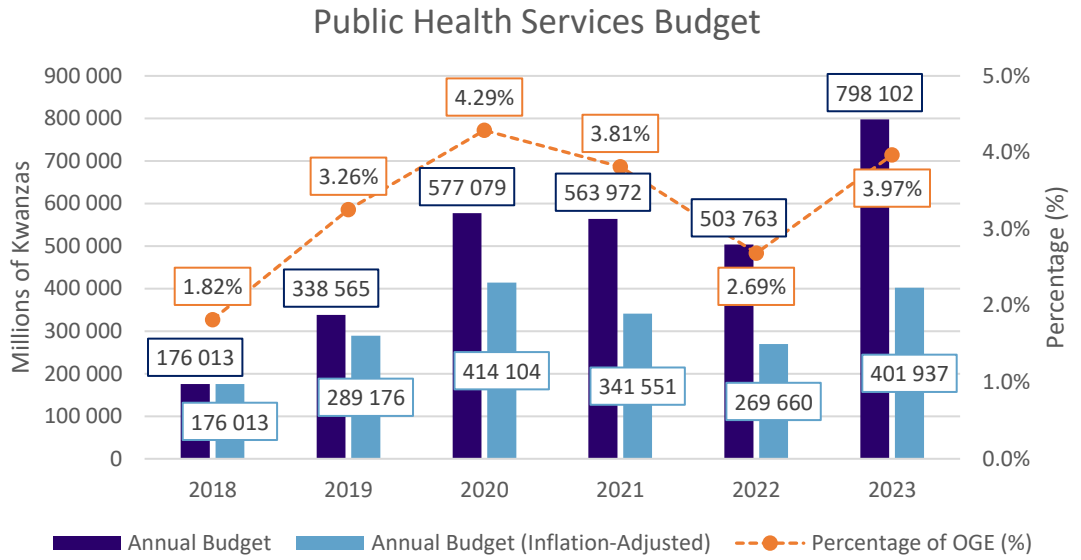


Figure 43. Public Health services budget and execution. Source: OGE and CGE 2018 – 2023.

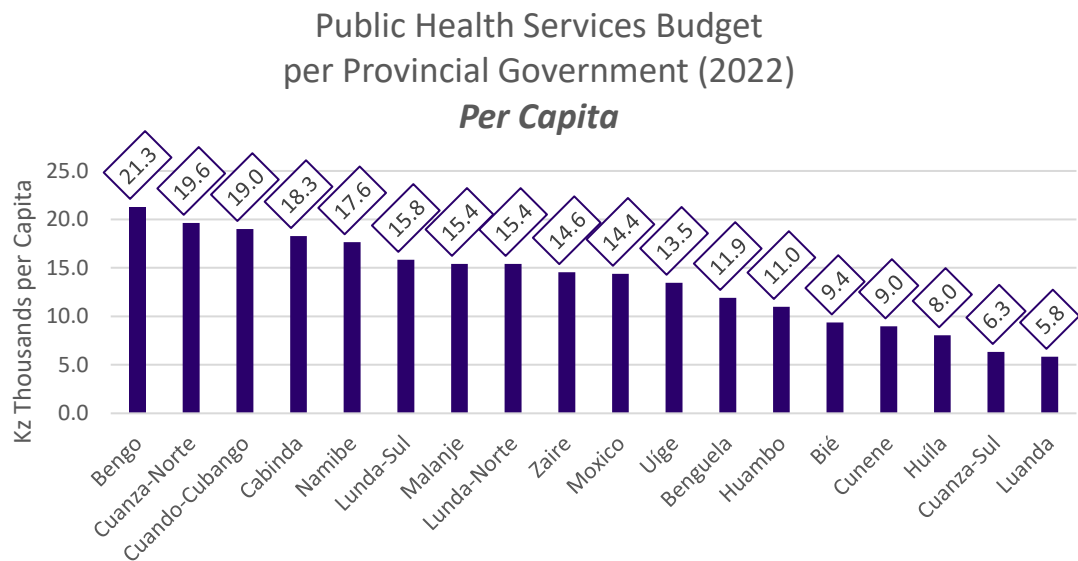
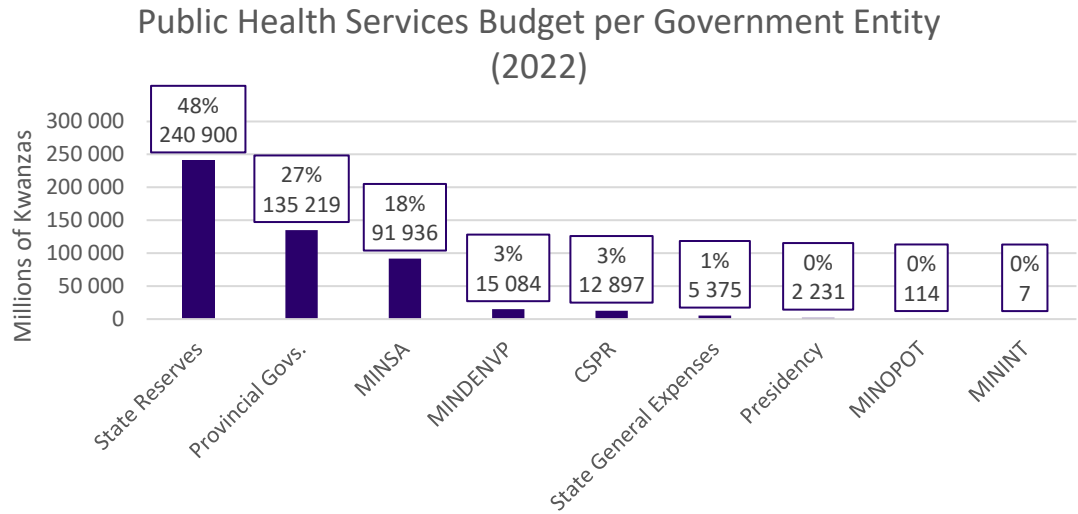


Figure 44. Public Health services budget per State Entity and Provincial Government per Capita. Source: OGE 2022.

5.1.3. Outpatient Services

The budget for Outpatient Services has been consistently below Kz 1 billion, with the exception of 2021, where an investment of Kz 7 billion was made in these services (Figure 45). In 2023, this budgetary unit was altogether removed from the OGE as a consequence of a restructuring of budget categories. Outpatient services were

incorporated into Public Health Services in order to eliminate redundancies in the budget.

In 2022, Mexico was the only Provincial Government to allocate part of its health budget towards these services.

Because the budget is relatively low (when compared with other health components), a small deviation from the projected amount leads to widely varying ratios of executed to approved budgets. For example, in 2021, the executed budget for Outpatient Services was 307.1% of the approved budget, although the nominal expenditure did not exceed Kz 2 billion.

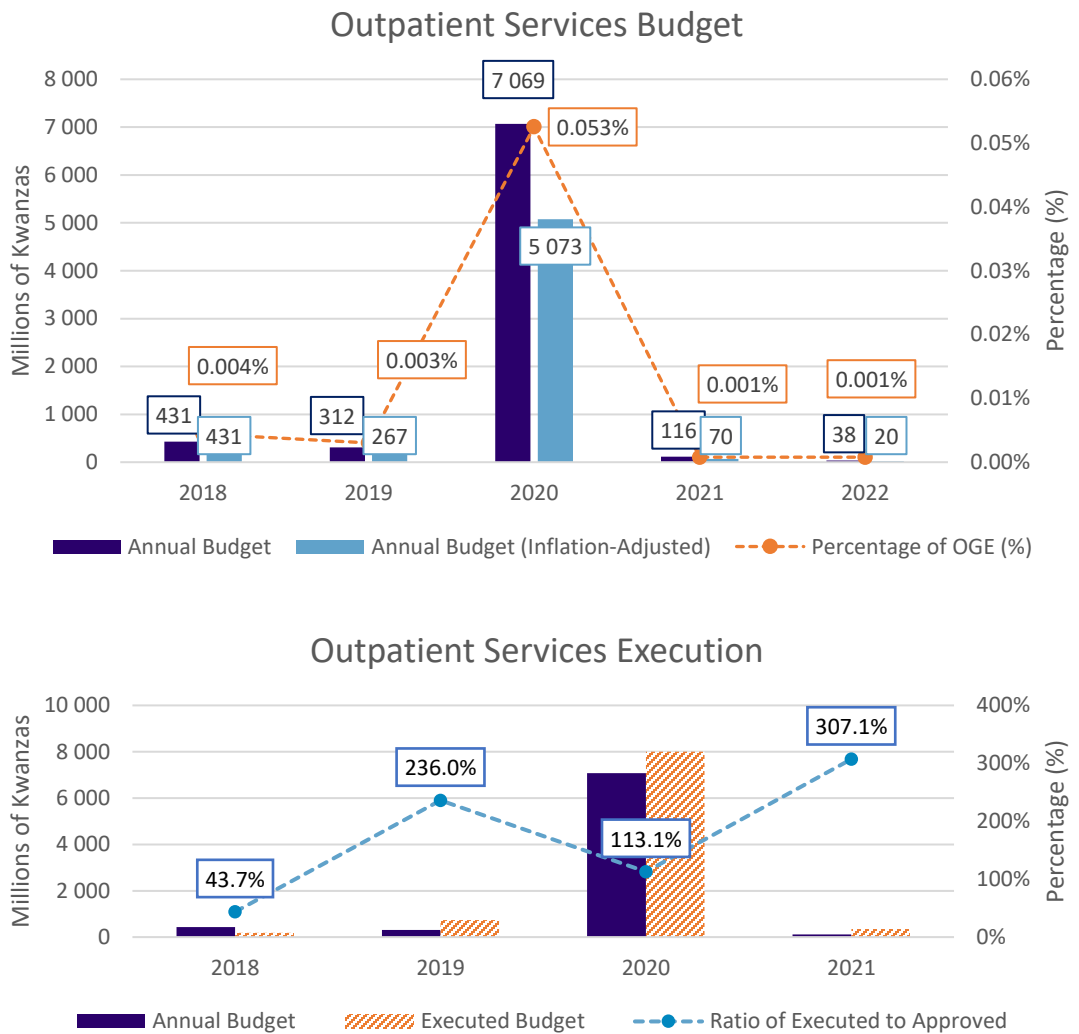


Figure 45. Outpatient Services budget and execution.

Source: OGE 2018 - 2023 and data by MINFIN.

5.2. Fight Against Major Endemic Diseases Program

5.2.1. Annual Budget and Execution

Concomitant to the budget allocated to Public Health Services, the government of Angola also funds the Program for the Fight Against Major Endemic Diseases Through Health Determinants Approach. This program aims to fight the challenges posed by the endemic diseases affecting Angola including Malaria, HIV/AIDS, Tuberculosis, and Tropical Neglected Diseases, through investment in prevention, early diagnosis, and treatment.

Most recently, the program also tackled mental health and oncological diseases, however the first stopped being reflected in the program's performance indicators as of 2022 and the latter was never reflected in the last five years.

Similarly to the Program for the Improvement of Maternal and Child Health and Nutrition, this is one of the longest running health programs of the Government.

Its budget in 2023 was Kz 45.1 billion, representing a decrease for two consecutive years (Figure 46) — despite the continued pressure of endemic diseases in the health sector, as seen in Chapter 2.1. This jeopardizes long-term planning for routine public health initiatives.

The executed budget for 2020 and 2021, according to the CGE, was Kz 3 billion and Kz 138 billion respectively.

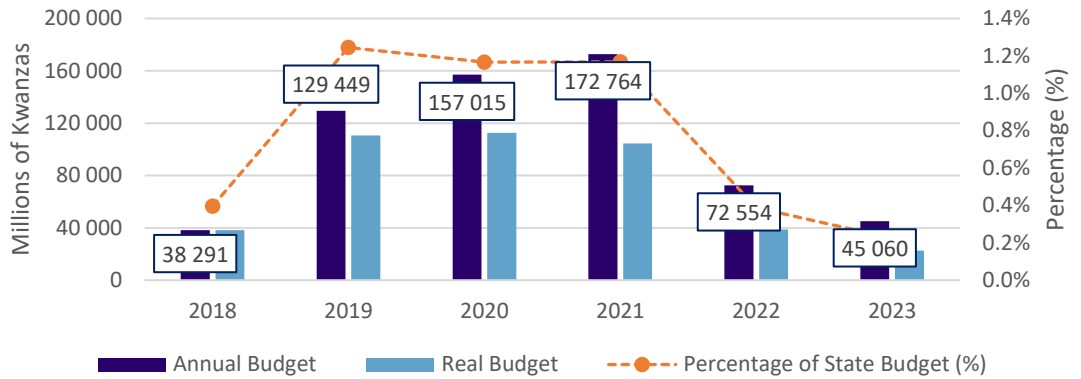
5.2.2. Distribution

The program's budget is mostly concentrated in the central Government. In this case, 80% of the programs budget was allocated to MINSA in 2022, 7% to Intelligence Services and State Security, 7% to State Reserves. With a further 3% directed towards the Presidency of the Republic, this leaves 3% of the budget to Provincial Governments — a total of Kz 1.8 million (Figure 47).

Within the provinces, Lunda-Sul had the largest budget when accounting for population (Kz 211 per capita), followed by Malanje (Kz 195 per capita) and Cuando-Cubango (Kz 174 per capita). On the opposite end of the spectrum, Luanda had a budget equivalent to Kz 11 per capita (Figure 48).

Meanwhile, two provinces approved zero funding for this program in 2022 — Cabinda and Namibe. Although it is harder to trace the provincial budget across time, it is clear that the budget per Provincial Government fluctuates from year-to-year, possibly due to shifts in the implementation of local projects.

Fight Against Major Endemic Diseases Through Health Determinants Approach Budget



Fight Against Major Endemic Diseases Through Health Determinants Approach Execution

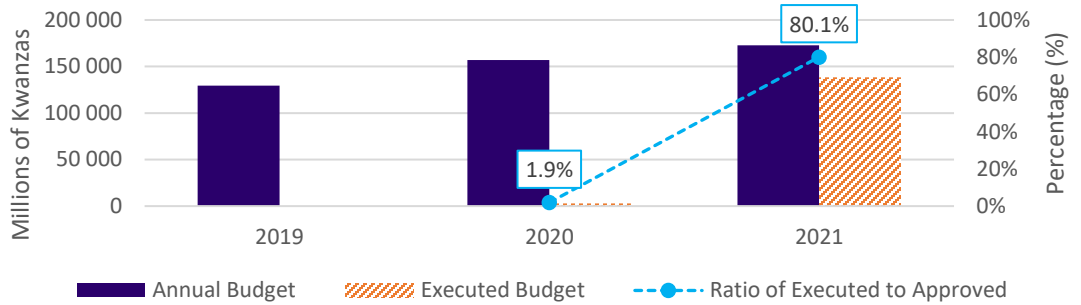


Figure 46. Fight Against Major Endemic Diseases Through Health Determinants Approach Budget and Execution. Source: OGE 2018 – 2023 and CGE 2019 – 2021.

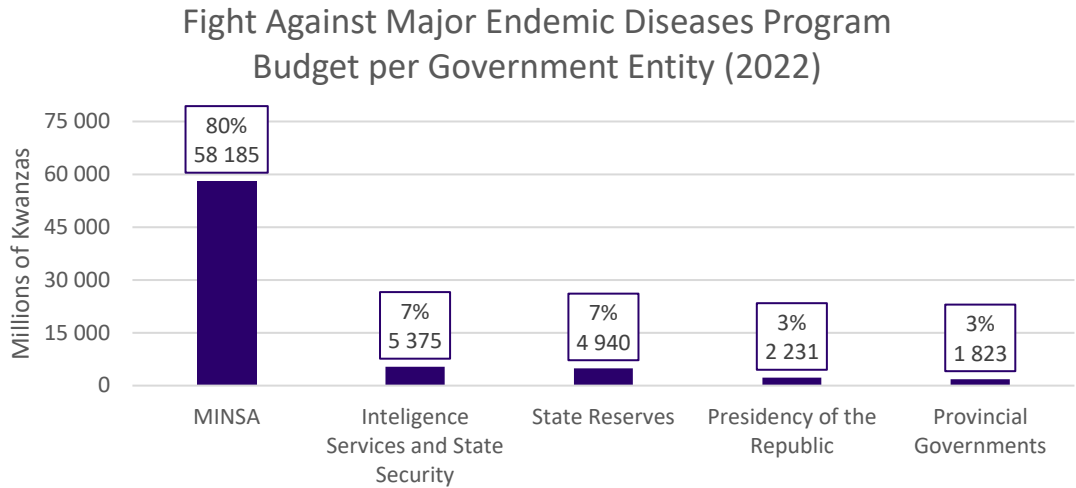


Figure 47. Fight Against Major Endemic Diseases Through Health Determinants Approach Budget per Government Entity. Source: OGE 2022.

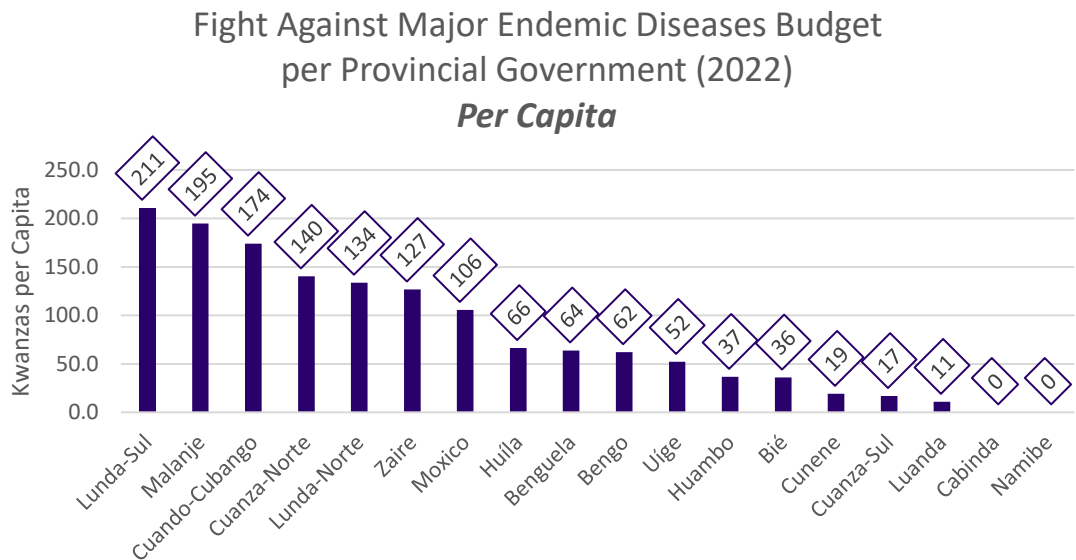


Figure 48. Fight Against Major Endemic Diseases Through Health Determinants Approach Budget per Provincial Government. Source: OGE 2022.

5.2.3. Performance Indicators

The Fight Against Major Endemic Diseases Program currently has 6 performance indicators, however, in the last few years the data accounted for a total of 12 indicators (Figure 49):

- Ten indicators were present in 2020, when data on them was first reported in the CGE.
- One indicator was introduced in 2022 (*i.e.*, HIV/AIDS mortality rate) and therefore only has data on its objectives and budget, but not results.
- One indicator was introduced in 2023 (*i.e.*, Mother-to-child HIV transmission rate), and therefore only has data on its budget for that year. For this reason, its data was not plotted.
- Six performance indicators removed in 2022:
 - i. Pregnant women who receive at least 4 TIP doses (%)
 - ii. Municipalities with integrated vector control teams (%)
 - iii. Cases of trypanosomiasis diagnosed and treated (%)
 - iv. Urinary and intestinal infections due to schistosomiasis (%)
 - v. Primary level health units with mental health services (%)
 - vi. Municipalities with operational public health emergency response teams (%)

While it is understandable that the government chooses to reduce the number of performance indicators in order to better focus the financial investment of the program, it is important to continue to address the issues previously reflected in the program. The government should therefore address these changes in its CGE for 2022, why they were made, how the performance indicators were restructured and what mechanisms were put in place to compensate for these removals.

Summary of Finding:

- 6/10 indicators (2020-2021) either met or went beyond their objectives in 2021.
- There has been a significant downsizing on the number of indicators in 2022, accompanied by a reduction in budget.
- Several indicators do not accurately reflect the burden of the disease in the population (*e.g.*, HIV/AIDS, Tuberculosis and Leprosy).

One of the most successful indicators within the program was the rate of Municipalities with operational public health response teams. In 2020, the planned objective was to have a rate of 40%, but the government was able to raise it to 100% and sustain that performance in 2021. This was in large part due to the deployment of

COVID-19 emergency response teams and training of surveillance technician's pandemic. An initiative that had the support of the Department for Hygiene and Epidemiological Surveillance (*Departamento de Higiene e Vigilância Epidemiológica*).

Equally successful, was the rate of diagnosed leprosy patients receiving multidrug treatment (MDT), which reached 100% in 2020 and 2021 (20 p.p. above the planned objective). The program's performance in this field is partly due to the training of 25 technicians in Neglected Tropical Transmissible Diseases and Case Management and the financial support of the Sasakawa Foundation.

In these two cases, it is again obvious that the objectives set for 2021 did not consider the results obtained in 2020, since they are lower.

Focusing on the performance indicator concerning leprosy, it can be argued that treatment rates alone do not necessarily reflect the true scope of leprosy's burden if treatment access and or diagnosis is not prevalent or easily available.

This is exactly the case for tuberculosis treatment success rate, which is high because a large portion of cases goes undiagnosed or (even when reported) patients do not undergo treatment⁷¹ — given Angola's low Universal Health Care coverage. This is particularly relevant as reported cases were reduced during the COVID-19 pandemic, but global estimated deaths increased in 2020 and 2021⁷² (even when accounting for lower transmission rates during lockdown periods). These indicators should be complemented by i) annual absolute number of TB deaths and ii) TB incidence rate, iii) TB diagnosed patients vs patients receiving treatment ratio, iv) stock.

A similar argument can be made for HIV/AIDS mortality rate, which alone does not provide significant information given the extensive underdiagnosis in the country. On this front, the government has rightfully introduced the rate of mother-to-child transmission of HIV as an indicator for 2023.

A Note on Methodology:

The analysis above is based on the OGE documents which list the budget per program and their targets (*i.e.*, *dotação por programa*). This is important because documents for the same year may not be entirely consistent between each other. Different indicators may be present in different documents concerning the same year, which is the case for this program in the year 2022.

⁷¹ Stop TB Partnership, [Tuberculosis Situation in Angola](#) (2020)

⁷² WHO, [Global Tuberculosis Report](#) (2022).

Planned Objective ——— End-year Result - - - - -

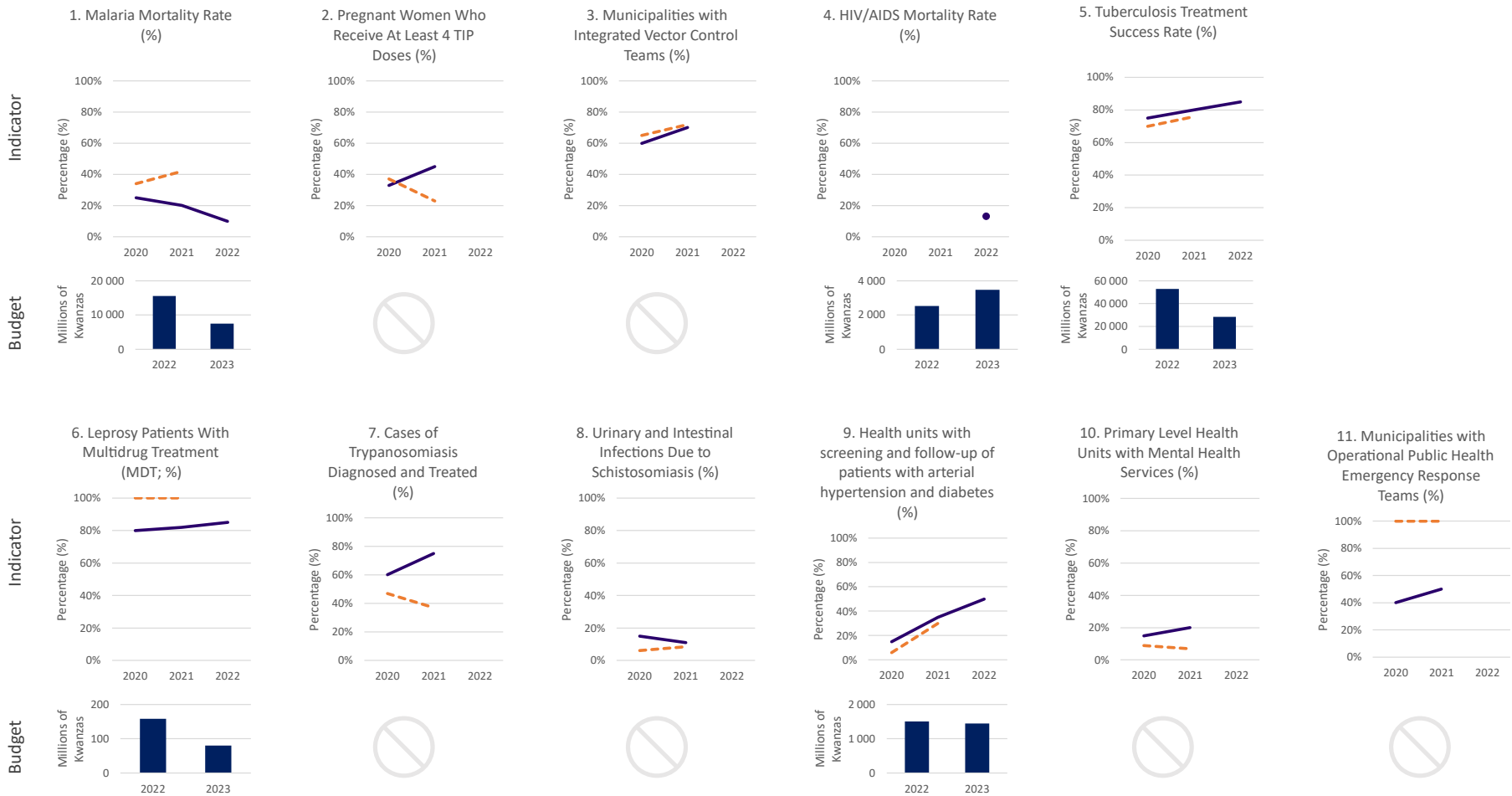


Figure 49. Fight Against Endemic Diseases Budget: Performance Indicators. Source: OGE 2022.

5.3. A Closer Look at Endemic Diseases

5.3.1. Malaria

Globally, there were 619 thousand deaths due to malaria in 2021 alone, out of an estimated 247 million cases⁷³. Malaria incidence has effectively increased as a result of the disruptions to essential malaria services during the COVID-19 pandemic, leading to an additional 63 thousand deaths between 2019 and 2021. The majority of these cases, and consequently deaths, occurred in Africa — a condition which is further aggravated by reports of growing resistant in the continent to anti-malarial drugs by the malaria causative agent *Plasmodium*⁷⁴.

The consequences of the COVID-19 pandemic in malaria statistics are also visible in Angola, where malaria is one of the leading causes of child mortality. The total number of estimated cases has been continuously increasing for the past decade and peaked in 2020 at 8.3 million cases. There was also a noticeable increase in malaria-related deaths in 2020, with an estimated number of 16.0 thousand deaths (Figure 50).

Mortality rate, whether measured as reported deaths per cases (as in the OGE) or measured as deaths per population at risk (as in the WHO data), has increased since 2019.

When compared to the African region, malaria incidence rate in Angola has surpassed the African average in 2019, while its mortality rate remains below average.

The evidence points to an increased burden of malaria in Angola; however, the annual budget does not seem to reflect such urgency. Funding towards the reduction of malaria mortality rate was reduced in 2023. Meanwhile funding for the administration of preventive malaria treatments among pregnant women (intermittent preventive treatment — TIP) and for integrated vector control teams has been removed as a performance indicator from the OGE 2022.

⁷³ WHO, [World Malaria Report 2022](#)

⁷⁴ WHO, [Strategy to respond to antimalarial drug resistance in Africa](#) (2022)

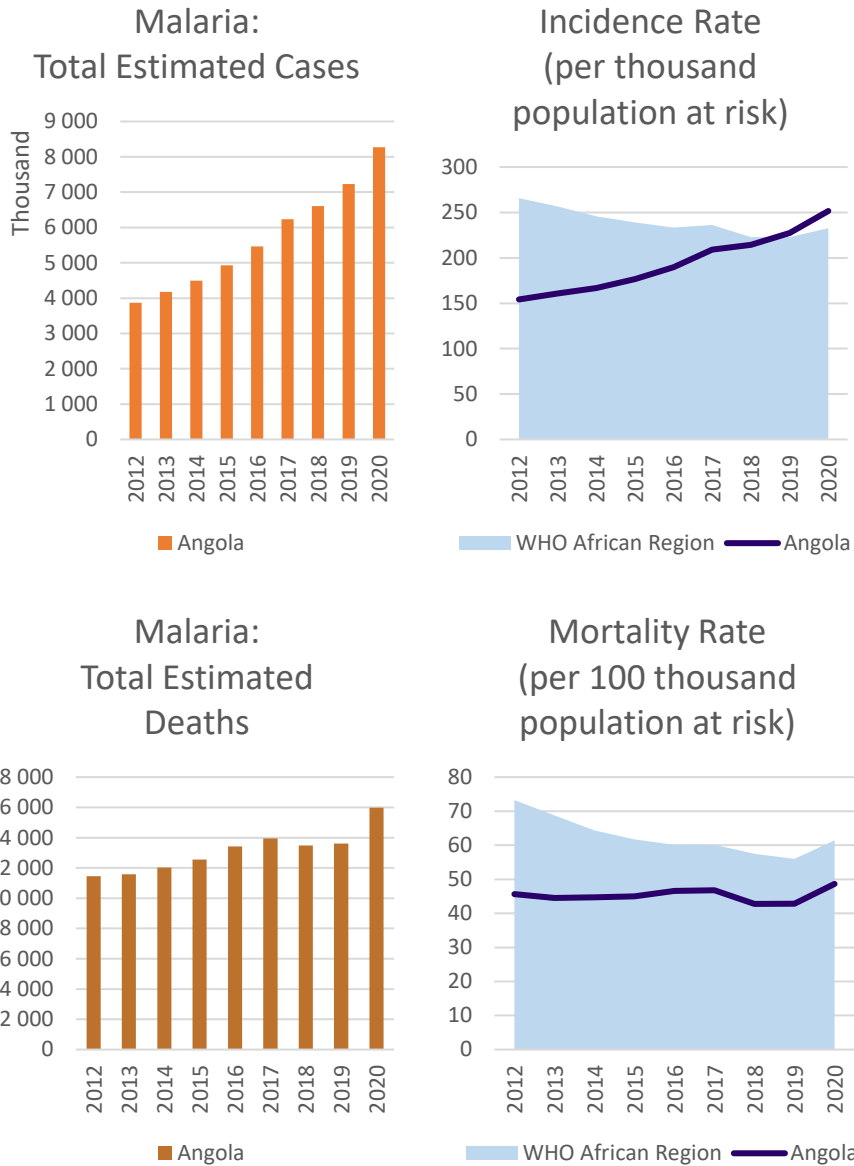


Figure 50. Malaria statistics. Source: WHO Global Health Observatory Data Repository⁷⁵.

⁷⁵ WHO [Global Health Observatory Data Repository](#)

If we compare the budget per province per capita of the Fight Against Major Endemic Diseases Program in 2022 with the prevalence of malaria in children 6 to 59 months reported in the IIMS 2016, it is possible to observe overlaps (Figure 51). In several cases the provinces with the highest reported malarial prevalence received the greater funding for the program in 2022 — for example Cuando-Cubango, Lunda-Norte, Malanje and Moxico. Meanwhile, several provinces with low malaria prevalence — such as Namibe, Huíla, Cunene and Huambo — received lower funding for the program in 2022. This shows that funding is being channeled to the provinces with higher apparent prevalence.

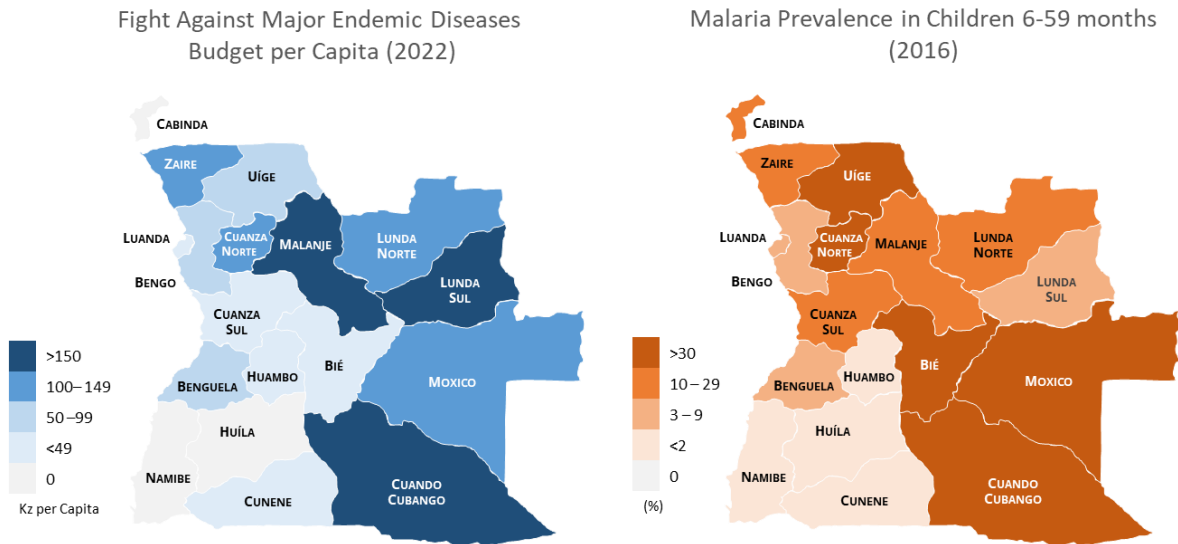


Figure 51. Fight Against Major Endemic Diseases Budget per Capita vs. Malaria Prevalence in Children — choropleth map of Angola. Source: OGE 2022 and IIMS 2016

5.3.2. Tuberculosis

According to the Global Tuberculosis Report^{76, 77} published by the WHO in 2022, Angola is one of the world's top 30 countries with high tuberculosis (TB) risk.

In 2021, Angola had an estimated 112.0 thousand cases of TB, which represents an incidence rate of 325 cases per 100 thousand population (Figure 52). The national incidence rate is significantly above the average for sub-Saharan Africa (112) and for the WHO African region (112). In fact, while the national and regional incidence rates have both declined since 2012, the regional rate has decreased at a faster pace than that of Angola.

Meanwhile, the total number of notified new and relapse cases admitted to treatment was roughly 61.7 thousand that same year — reflecting a 55% treatment coverage when considering the total estimated cases (5 p.p. lower than the average for the WHO African Region). If we include TB patients who had been previously treated and whose treatment either failed or had an unknown outcome, total notified cases go up to 64.0 thousand.

The country is also one of the top 30 with high Rifampicin Resistant-TB/ Multidrug Resistant-TB risk. It is estimated that the annual percentage of new cases with Rifampicin Resistant-TB is 3.5% since 2016 — which translated to 3.9 thousand cases in 2021.

However, as of 2022 it is no longer considered one of the top 30 countries with high TB/HIV risk. In 2021, the WHO estimated a total 14.0 thousand cases of TB in HIV-positive patients — that is, 12.0% of total estimated cases. A slight increase from 2019 (7.6%), but a significant decrease from 2012 (25.0%)

Regarding treatment outcomes, data for 2021 was not available, however the previous year may be considered representative of the current outlook. In 2020, there was a total of 34.1 thousand successfully treated tuberculosis patients. This represented a success rate of 53%⁷⁸, which is 7 p.p. below the average for the WHO African Region.

Between 2012 and 2021, tuberculosis has caused on average a total of 23.7 thousand deaths per year — 21.0 thousand in 2021.

The report also points out that the country's TB reporting mechanisms have not completely recovered from the impact of the COVID-19 pandemic and that Angola lacks a specific National TB Surveillance Survey.

⁷⁶ WHO, [Global Tuberculosis Report](#) 2022

⁷⁷ WHO, [Global Tuberculosis Program Data Repository](#)

⁷⁸ The success rate is determined considering that the treatment follow-up cohort was 64.9 thousand patients out of a total of 66.1 thousand cases that year.

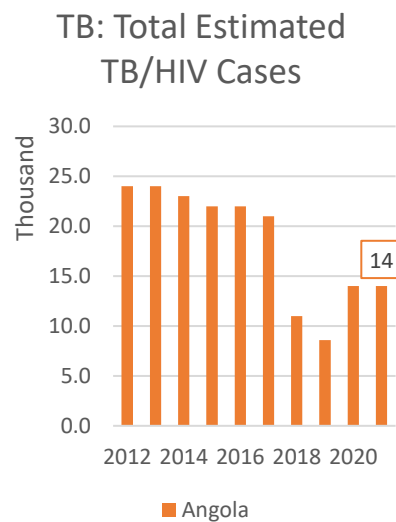
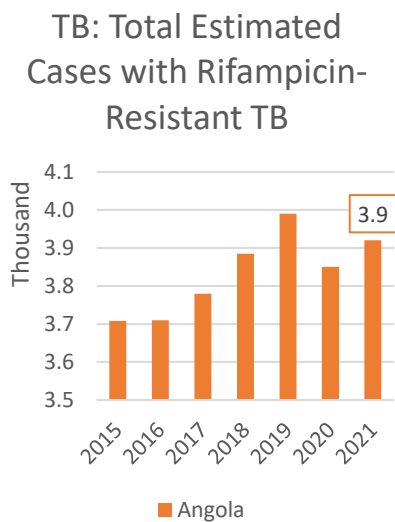
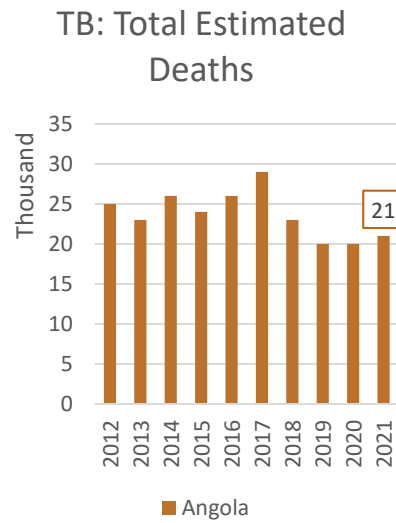
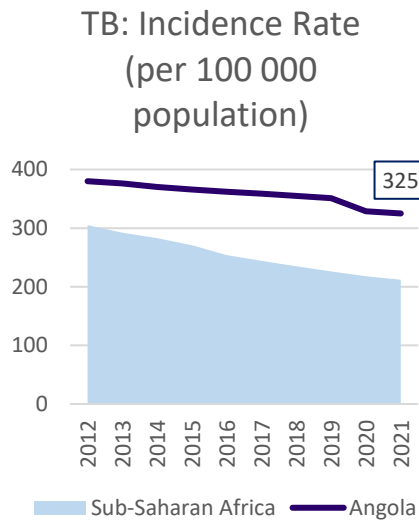
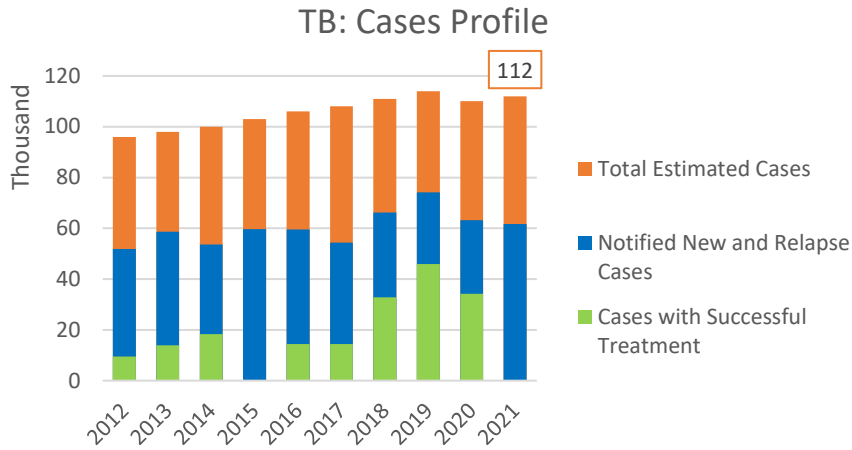


Figure 52. Tuberculosis statistics. Source: WHO Global Tuberculosis Program Data.

Regarding the funding for the prevention and treatment of TB, the WHO reports that Angola had a total expected funding of US\$ 10.2 million (Kz 6.5 billion) for 2021 (Figure 53). Domestic funding would represent 59% of total funding, *i.e.*, US\$ 6.0 million (Kz 3.8 billion), and the remaining US\$ 4.2 million (Kz 2.7 billion) would come from international sources.

In reality, total expenditure in 2021 was only US\$ 7.6 million (Kz 4.9 billion). While the government contributed with almost the expected amount — US\$ 5.6 million (Kz 3.6 billion), international funding was lower than expected, *i.e.*, US\$ 2.0 million (Kz 1.3 billion). More specifically funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria was lower than expected.

Altogether, domestic funding contributed to 73% of total tuberculosis expenditure, which is far greater than the average of 51% for the WHO African Region.

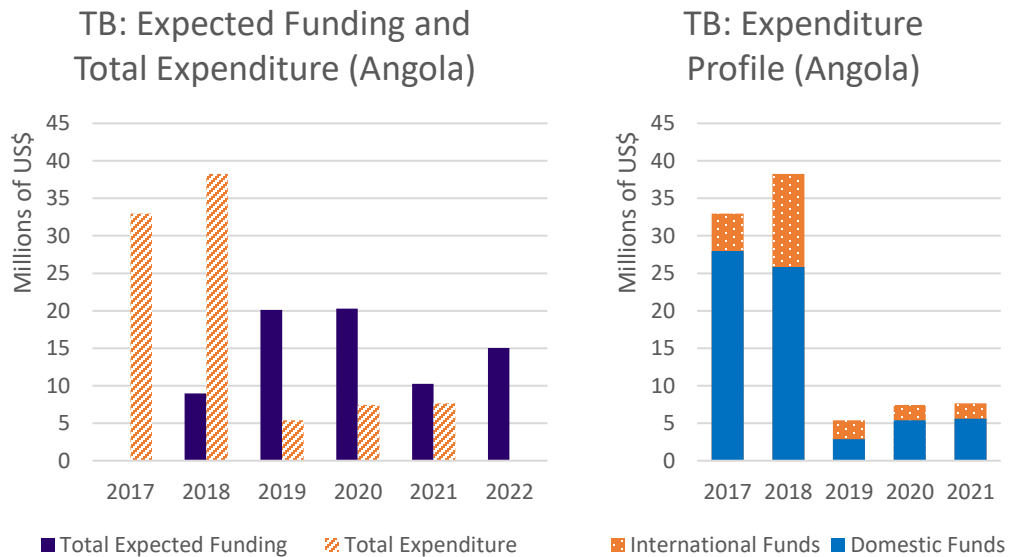


Figure 53. Tuberculosis Expected Funding and Expenditure.

Source: WHO Global Tuberculosis Program Data.

Lastly, we also note that the data reported for 2022 by the WHO is not consistent with the Government data presented in Figure 49 (and Annex). While the purported budget for the increase of the “Tuberculosis treatment success rate” was Kz 52.8 billion, the expected domestic funding for tuberculosis in 2022 — according to the WHO — is only US\$ 10.8 million (Kz 5.5 billion).

5.3.3. HIV/ AIDS

As discussed in Chapter 2.1, HIV/AIDS is the second leading cause of deaths in Angola with 17 thousand new HIV estimated infections and approximately 15 thousand HIV-related deaths in 2021 (Figure 54)⁷⁹. The national prevalence ratio is currently 5.4 new cases per a thousand population, which is higher than the 3.3 ratio of the East and Southern Africa region. As per the mortality ratio, it is currently 1.0 deaths per a thousand of population. While prevalence is higher, mortality is below the 1.5 ratio reported for East and Southern Africa.

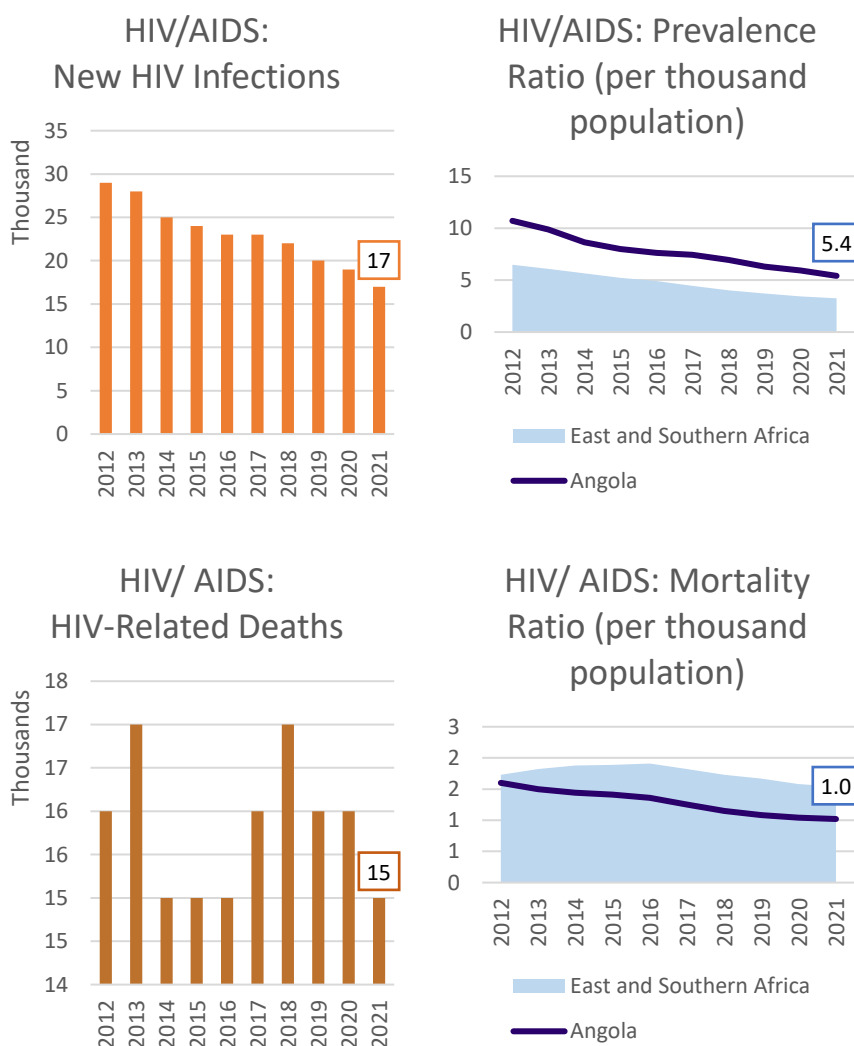


Figure 54. HIV/ AIDS statistics. Source: UNAIDS.

⁷⁹ UNAIDS, [AIDSINFO Data Portal](#)

Although tremendous efforts have been undertaken to reduce the burden of HIV, Angola remains far from achieving the **95-95-95 AIDS Targets** established by UNAIDS in the Paris Declaration⁸⁰. That is, to achieve:

- 95% of people living with HIV knowing their status
- 95% of people who know their HIV-positive status are on treatment
- 95% of people HIV-positive on treatment with suppressed viral load

Currently the country presents the following statistics according to UNAIDS⁸¹:

- 57% of people living with HIV in Angola know their status
- 41% of people who know their HIV-positive status in Angola are on treatment
- Data on suppressed viral load is not available

Despite the current scenario, the budget for the Program for the Fight Against Major Endemic Diseases decreased in 2022 — as seen in Chapter 5.2. Furthermore, the budget for the National Institute for the Fight Against AIDS declined by almost half from 2021 to 2022 (Figure 55). In 2023, the institute’s budget was again raised (up to Kz 8.7 billion). We were unable to assess the institute’s expenditure.

Albeit, according to UNAIDS, government-reported HIV public expenditure was US\$ 24 million (Kz 15 billion) in 2021 — four-times the expenditure reported in the previous year. International funding amounted to US\$ 4.1 million (Kz 2.3 billion) in 2021 — equivalent to 15% of the total funding. We were unable to corroborate these data.

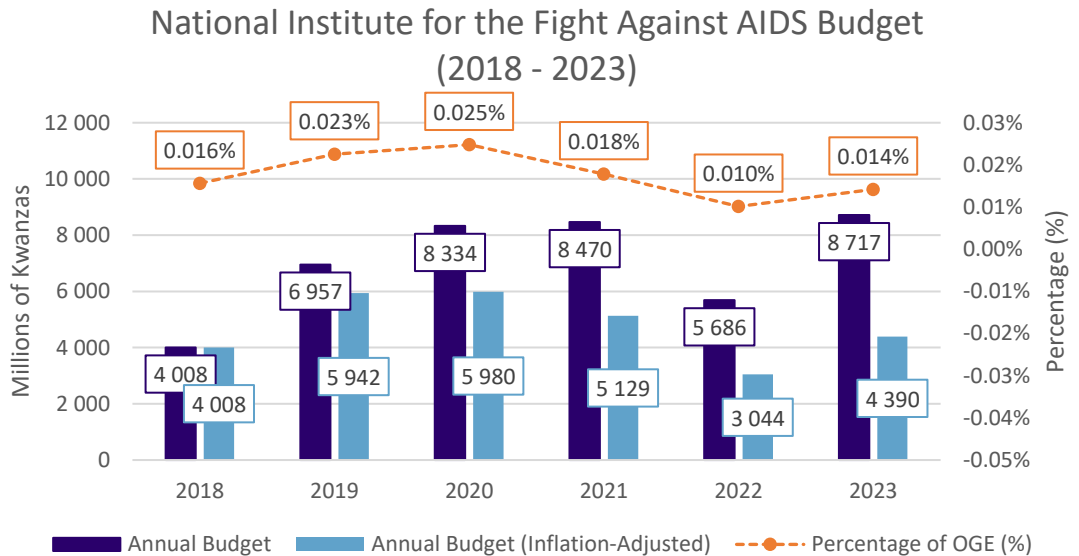


Figure 55. National Institute for the Fight Against AIDS Budget. Source: OGE 2018 – 2023.

⁸⁰ UNAIDS, [Paris Declaration](#) (2014)

⁸¹ UNAIDS, [Country Profile: Angola](#)

5.4. Emergency Response to COVID-19

The response of the Government of Angola against the COVID-19 pandemic was relatively swift and effective, within the African paradigm, albeit considerably underfunded.

Angola's two first cases of COVID-19 were reported in Luanda on March 21st of 2020⁸². Soon after, on March 26 President João Manuel Lourenço declared a National State of Emergency to take effect on the following day. This swift response put in motion Angola's emergency pandemic response against the COVID-19 pandemic.

This response has been recently documented from a Public Finance perspective by the World Health Organization in a soon to be published report, titled — *Public Finance management in the context of the COVID-19 pandemic response in Angola*⁸³.

According to the data collected, total public expenditure in the fight and prevention of COVID-19 between 2020 and 2021 was Kz 266 billion (US\$ 437 million) — the equivalent to Kz 8.1 thousand per capita. Kz 124 billion in 2020 and Kz 141 billion in 2021. This was largely funded by the Treasury of Angola, with loans and financial donations playing a secondary role.

If we add the expenditure in the fight and prevention of COVID-19 to the annual health expenditure, the sum of the two is Kz 686 billion and Kz 949 billion for 2020 and 2021, respectively. An increase in the annual health expenditure of 22 p.p. in 2020 and 17 p.p. in 2021.

The three most significant expenses over those two years were (from the largest to smallest) the acquisition of vaccines against COVID-19, the establishment and provisioning of emergency campaign hospitals and the purchase of ventilators.

To this day Angola has reported a total of 105 thousand cases of COVID-19⁸⁴, that is 2.9 thousand cases per million people — significantly below average for the WHO African region, even when considering the countries reduced monitoring capacity.

Roughly 23.7 million doses of vaccines against COVID-19 were administered up to December of last year⁸⁵, as part of the National Vaccination Plan against COVID-19, which has culminated in an immunization coverage of 42.1%. The launch of the national immunization campaign in 2021 was exemplary and successful, earning international praise⁸⁶. The pace of vaccination has since slowed down, in part due to a decreased sense of urgency and in part due to the difficulties in equal distribution withing the provinces.

⁸² Jornal de Angola, [Retrospectiva/2020: Os dois primeiros casos positivos de Covid-19 em Angola vieram de Portugal](#) (2021)

⁸³ WHO, [Gestão das Finanças Públicas no Contexto da Resposta à Pandemia COVID-19 em Angola](#) (2022) — Unpublished.

⁸⁴ Our World in Data, [Angola: Coronavirus Pandemic Country Profile](#) (Data from the John Hopkins University)

⁸⁵ Our World in Data, [Total COVID-19 vaccine doses administered](#)

⁸⁶ WHO, [Inside Angola's 'exemplary' COVID-19 vaccination hubs](#) (2021)

The pandemic response was coordinated by the Multisectoral Commission for the Prevention and Fight against COVID-19, whose budget was presented separately in the Whole of Government Accounts for those two years. Meaning that it was technically not included into the Health Expenditure — although programs such as the Improvement of Maternal and Child Health and Nutrition and the Fight Against Major Endemic Diseases saw a significant decrease in their executed budgets.

In 2022, the Commission appeared to have been included as a component within the Fight Against Major Endemic Diseases Program, although this is only reported in the documents that lists the “budget per government entity” (*dotação por órgão*) and not in the documents that list the “budget per program” (*dotação por programa*). However, according to the Budget Execution Reports for the First and Second Trimesters, the Commission’s spending continues to be treated separately from the Fight Against Major Endemic Diseases Program.

The CGE for 2022 will hopefully provide a definitive framing once it is released.

Furthermore, MINSA also included in its annual budget a current expense titled the “COVID-19 Prevention and Combat Costs” which was Kz 4.2 billion in 2022, and Kz 16.2 billion in 2023.



6. Conclusions and Recommendations

6.1. Key Conclusion

1. **There is a severe inconsistency between health and nutrition policy documents.**

Although the Government of Angola has repeatedly prioritized health and nutrition in its policy instruments across the years, these documents are not consistent between themselves. While the general objectives of the National Sanitary Development Plan 2012 - 2025 are present in the PDN 2018 — 2022, the detail and targets do not translate well. In fact, the National Sanitary Development Plan 2012 - 2025 is outdated. This is a problem which the Ministry of Health is aware of and is currently working towards updating the document.

The subject of nutrition is particularly striking because neither the National Food and Nutrition Security Strategy (2009), the PDN 2013 — 2017, the National Sanitary Development Plan 2012 - 2025 nor the PDN 2018 — 2022 have aligned objectives. Furthermore, nutrition targets are also not aligned with the international WHO/UNICEF targets and recommendation as detailed in Chapter 3.1.1.

2. **Health and nutrition policy is sometimes not reflected in the General State Budget.**

Targets established in the PDN 2018 - 2022 sometimes are not reflected in the OGE. Most noticeably two targets established for the program for the Improvement of Maternal and Child Health and Nutrition established in the PDN 2018 - 2022, were not presented in the OGE — *i.e.*, i) have 80% of children under six-months old with exclusive breastfeeding and ii) to eliminate neonatal tetanus — both by 2022. Additionally, in the program for Strengthening of the Health Information Systems only 3 out of 5 targets are actually being monitored.

Regarding the National Sanitary Development Plan 2012 - 2025, there appears to be no direct relationship between its objectives and the performance indicators of programs in the OGE.

3. **It is currently impossible to implement a results-based budgeting strategy.**

The last National Demographic and Health Survey in Angola (*i.e.*, IIMS) was performed in 2015 - 2016. A new survey was expected to take place in 2020 - 2021, however, it

has been delayed due to the COVID-19 pandemic. This effectively means that there has been no nationally representative health survey in Angola for the past 7 years.

Lack of monitoring for accurate data makes it impossible to implement a results-based budgeting strategy or to analyze the efficiency of budget spending. It also results in situations such as the one described before for measles immunization coverage, where different sources provide different coverage values — thus undermining confidence in the data.

4. Health program objectives are not defined based on the results from previous years.

After analyzing the health programs, it becomes clear that the targets of the performance indicators are not adjusted considering the previous year results.

In the program for the Improvement of Medical and Medication Assistance there are several scenarios where the targets continue to increase annually, even when the results obtained are either stagnant or have in fact decreased. For example, the percentage of Municipal teams that analyze the municipal health situation decrease between 2020 and 2021, but the target continued to increase, nonetheless. This shows that the objectives are planned beforehand for a long-term period (usually according to the PDN 2018 – 2022) and are not readjusted according to the results.

The opposite can also happen. For example (in the program for the Improvement of Maternal and Child Health and Nutrition) the institutional maternal mortality rate registered 170 deaths per 100 000 live births in 2019, but the target for 2020 was a ratio of 213 death. Meaning that instead of lowering the mortality ratio, the purpose was to raise it. This was obviously not the intent but shows that the objectives were not adjusted.

After consulting with multiple government entities in the sector, it become clear that there are logistic challenges in updating annual performance indicators and targets, a process which must go through the Ministry of Economy and Planning (MEP).

5. The health budget continues to be strongly centralized, despite recent improvements.

Provincial Governments represented 38% of the health budget in 2022, while 31% was allocated to MINSa. The remaining budget (31%) stayed within the Central Government. Within MINSa, 76% of the budget was allocated to the Ministry itself as a budgetary unit, while the remaining 24% was redistributed by hospitals, medical centers and institutes. It is also worth noting that a part of the expenditure carried by the Ministry of Health goes to primary healthcare interventions such as the bulk purchase of medication which is later distributed per Province.

MINSAs also needs further detail on the budget allocated to Provincial Governments and how it is applied, in order to avoid double spending. This information can either be provided directly by the Provinces or through MINFIN.

Overall, MINSAs as a budgetary unit (excluding hospitals, medical centers and institutes) represented one quarter of the total health budget.

Specialized Hospital Services are especially centered in MINSAs, which represents 80% of the services' budget. The Central Government also plays a significantly major role in the vast majority of health programs.

6. Routine immunization is underfunded.

As described in Chapter 4., Angola's total expenditure on routine immunization is relatively low, which has negatively impacted rates of immunization against deadly and life-crippling diseases. This has obvious negative effects like the measles outbreaks of 2022.

6.2. Recommendations

The assessment performed in the previous Chapters led to the development of 8 recommendation towards the betterment of the health and nutrition sectors in Angola, which will be discussed below. These recommendations are clustered in the following three categories as illustrated in Figure 56:

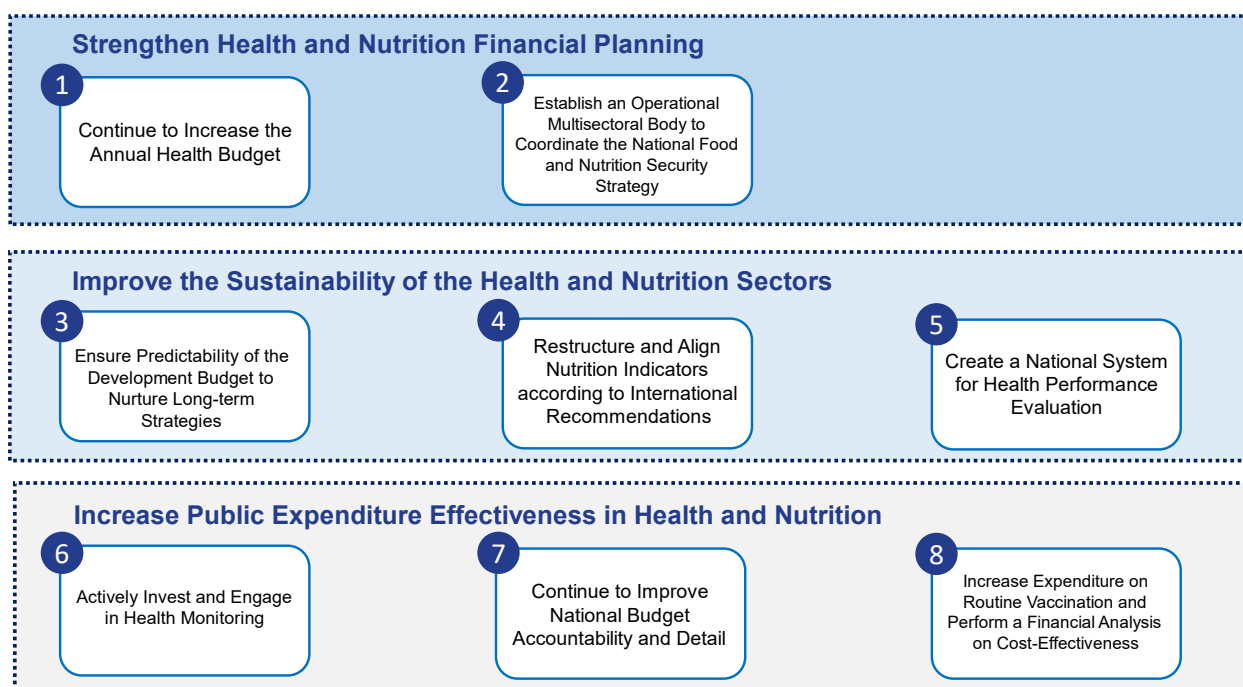


Figure 56. Recommendations framework.

6.2.1. Continue to Increase the Annual Health Budget

Angola has a long way to go to achieve universal health coverage and in order to do so it requires a greater financial commitment on behalf of its Government. A need to increase public spending on health had been identified in the World Bank Public Expenditure Review of 2007⁸⁷, and — although there have been major advances — it continues to be a key recommendation today.

According to the general state budget for 2023, the Government of Angola will increase the percentage of the annual health budget up to 6.7%. A welcomed decision which inverts the downward trend observed between 2019 and 2021. This makes it one step

⁸⁷ World Bank, European Commission, Food and Agriculture Organization, United Nations Children’s Fund, United Nations Development Program, World Health Organization (2007). [Angola: Public Expenditure Review, Volume 1. Policy Briefing and Volume 2. Sectoral Review.](#)

closer to the commitments made in the Abuja Declaration of 2001 to allocate 15% of the OGE towards the health sector.

If we assume that the OGE will grow by 16% every year (the average of the past 10 years), the Government will need to increase the health budget by 42% annually until 2027 or by 30% annually until 2030, in order to achieve its Abuja commitment.

The budget increase would ideally be guided by an updated National Sanitary Development Plan; and strengthen preventive programs such as those focusing on maternal and child health, nutrition and endemic diseases. These have been getting less allocation as compared to other services — a trend which can perpetuate long-term spending in the treatment of preventable diseases.

Another approach to raise investment that might be used is taxation of products with a negative Public Health impact, such as tobacco, alcohol and/ or sugary drinks, as has been implemented with success in different settings.

The increase in the annual budget, however, is only beneficial if followed by a successful execution of the budget allocated. Thus, it is important for the Government to continue the good performance observed in 2021 and not revert to the low execution rates observed in previous years.

The same applies to the Provincial Governments. As demonstrated in Chapter 2.2, nearly half of the provinces reported a ratio of executed budget below 90% of the approved budget in 2021 — some of them on a systematic basis (between 2018 and 2021). The practices adopted by those Provincial Government whose executed budgets in health are closer to 100% of the approved budget (*e.g.*, Huambo, Bié and Huíla) should be further studied as a means to increase budget efficiency in the other provinces.

6.2.2. Establish an Operational Multisectoral Body to Coordinate the National Food and Nutrition Security Strategy

The governance of the nutrition sector is fragmented between MINSA and MINAGRIF. Although this is understandable due to the nature of the subject, it is imperative that there should be an effectively operational body responsible for coordinating the National Food and Nutrition Security Strategy. This body should act as the link between the nutrition-specific interventions implemented by MINSA, and the nutrition-sensitive and -enabling interventions developed by MINAGRIF. It would also be responsible for leading monitoring efforts on nutrition indicators, compiling information and disseminating data. Via this body, MASFAMU, the Ministry of Fishery and the Ministry of Education could also be fully integrated into a wider national nutritional response. The Government of Angola has taken steps towards this direction through the

establishment of the National Multisectoral Platform for Nutrition; however, we were not able to determine whether or not the platform is active.

The Government should seek to reactivate this platform and/or to provide the means to make this multisectoral body more operational. This would in turn fuel interaction with international platforms such as the Scaling-Up Nutrition Movement.

Once the platform develops and grows successfully, its organizational structure can be mimicked and adopted to address other health determinants.

6.2.3. Ensure Predictability of the Development Budget to Nurture Long-term Strategies

The budget for development programs is not always stable, which hinders the development of long-term projects and strategies. Here, we are not referring to the nominal budget which is obviously dependent on the total Annual State Budget, but to the percentage of OGE which is allocated to programs and furthermore to the execution of said budget.

Each program should have a medium to long-term investment plan — adjacent to the National Development Plan — where the government would commit to providing consistent funding towards the program over the course of for example, a five-years period. This would ensure that those coordinating the programs would be able to plan and implement long-term projects.

Additionally, the fact that the budget is allocated on a monthly basis prevents adequate resource mobilization. One would need to have at least a part of the budget that would be fixed and able to be used across different months, namely because public contracting procedures tend to require long periods of time.

6.2.4. Restructure and Align Nutrition Indicators according to International Recommendations

On the subject of nutrition, the performance indicators set in the national policy documentation and traced in the CGE are not fully aligned with international practices. We propose that Angola adopt the four indicators and respective targets defined in the WHO Global Nutrition Targets 2025⁸⁸ and the WHO/UNICEF extension of the target to 2030⁸⁹, within the scope of the Program for the Improvement of Maternal and Child Health and Nutrition.

⁸⁸ WHO, [Global nutrition targets 2025: policy brief series](#) (2014)

⁸⁹ WHO/UNICEF, [The extension of the 2025 maternal, infant and young child nutrition targets to 2030](#) (2019)

These indicators are: i) women of reproductive age with anemia, ii) low birth weight, iii) exclusive breastfeeding in the first 6 months, as well as iv) under-five stunting, wasting and overweight.

These are also covered by the recent Global Action Plan for Child Wasting launched in 2019 by five United Nations Agencies — including UNICEF⁹⁰.

Furthermore, given the country's context and the benefits of vitamin A supplementation, Angola should also again include supplementation of vitamin A to children between 6 to 59 months old as a performance indicator of the program for Improvement of Maternal and Child Health and Nutrition. That specific indicator has been removed from the budget as of 2022, although the practice of providing vitamin A supplementation has not ceased. It is important that it remains a key performance indicator because that allows for a better tracing of the investment and its results.

6.2.5. Create a National System for Health Performance Evaluation

Decentralization in the basic healthcare network can lead to improved efficiency as local health authorities are better able to identify and respond to the specific health needs of their populations. As such, the Government of Angola has taken large steps in recent years towards decentralization by establishing Provincial Cabinets of Health and Municipal Health Departments. It has inclusively given greater autonomy to Provincial Hospitals over their budgets and spending — with MINSA being responsible for defining budget ceilings.

However, without a mechanism to assess performance and return-on-investment, further steps towards budget decentralization will be impaired.

To this end, Government of Angola should establish a National System for Health Performance Evaluation (SINAS, *Sistema Nacional de Avaliação em Saúde*) responsible for monitoring hospital and health centers' performance.

The system would have the following functions:

- A. Periodical collection of data from health facilities on their performance and financial status (*e.g.*, assisted births performed, percentage of c-sections, financial statements, etc.).
- B. Public disclosure of the data collected, accompanied by a comparative analysis of health facilities (*e.g.*, rankings, available services, etc.)
- C. Collaboration with government entities and multilateral organization in the development of best practices and guidelines on how to enhance performance.

⁹⁰ [Global Action Plano for Child Wasting](#)

The National System for Health Performance Evaluation would ideally be an independent entity whose information would be available to the wider public on an online platform to disclose the data collected from public health facilities.

This platform would provide the Central Government with a mechanism to identify health facilities with strong performance and return-on-investment as well as those underperforming. This information could then be used to justify the allocation of funds towards local health providers and the decentralization of the budget. Entities which have performed optimally would also have more leverage to negotiate their budget, and credibility to stipulate their needs.

Furthermore, such a platform could serve as the basis to increase the involvement of local health facilities in the budget design through a more tailored approach to budgeting based on specific needs of the institution itself (including those operating in the informal market).

6.2.6. Actively Invest and Engage in Health Monitoring

As previously discussed, there is currently a lack of monitoring in the health sector in Angola. The analysis on the current status of health and nutrition presented in Chapter 2.1. shows how outdated a large portion of the data is. The chapters addressing maternal and child health challenges and specific diseases also highlight the frequent reliance on estimations based on the IIMS 2016 survey and conflicting data among sources. This had inclusively been an issue identified in the World Bank Public Expenditure Review of 2007⁹¹, and continues to be a challenge today.

It is important for the Government to restart nation-wide surveys and ensure that they are regularly performed, enabling health data to be available in time to monitor trends and allow for interventions when required. The content of the data should also be addressed, ensuring all Health Determinants are considered.

Data collection at health facilities should also be further improved. To this end, there should also be an increase in funding for the program for the Strengthening of the Health Information System and Development of Health Research — the program which is responsible for the implementation of the Epidemic Outbreak Reporting System (Vid-R) and the Digital Health Information System (DHIS2). — the largest health monitoring information system platform in the world, currently implemented in over 100 countries.

Currently, DHIS2 is implemented in every Province and Municipality of the country, according to MINSA. The next step in its implementation is to equip every health facility

⁹¹ World Bank, European Commission, Food and Agriculture Organization, United Nations Children’s Fund, United Nations Development Program, World Health Organization (2007). [Angola: Public Expenditure Review, Volume 1. Policy Briefing and Volume 2. Sectoral Review.](#)

with the technology (computers and internet) and human capacity necessary to report data remotely and automatically. As of now, some facilities still report data manually; this information is then physically gathered from multiple health units and inserted into the system at a central facility with the technological capacity for it.

Ideally, MINSA would disseminate the data within the health ecosystem and inclusively publish reports on the data collected on a routine basis to the wider public.

Workforce capacity is also a concern and despite a significant increase in the number of graduates in Health Professions (namely in nurses and health technicians from public and private Higher Education Institutions), a closer look into their capacity training should be addressed, including management and communication competencies.

6.2.7. Continue to Improve National Budget Accountability and Detail

State Budgets and Whole of Government Accounts have become increasingly more detailed and informative, including extended information on the development programs in the budget. For example, the sub-function non-specific health services has been removed as a category in 2013. Most recently, the Government began to report on the budget allocated to each program performance indicator at the beginning of 2022, which is a significant step towards transparency and accountability.

Overall, Angola is currently compliant with vast majority of the best practices defined by the OECD on Budget Transparency⁹². However, there is still room for progress in the Health and Nutrition sectors.

1. **The Government should make information on the budget's execution more readily available.** Data on the executed budget for sub-function (*i.e., General and Specialized Hospital Services, etc.*) was made quickly available to the analytic team upon request directed to MINFIN. However, there is no reason such data should not be publicly available in the CGE. The same is true for data on the execution per function of the budget allocated to Provincial Government, this would allow a better understanding of the Provinces performance per sector (Health, WASH, etc.).
2. **The budget execution of Provincial Government per budget function and sub-function should also be detailed in the CGE.** Data on the expenditure by Provincial Governments is difficult to assess. While data on the subject was provided by MINFIN, there is no reason why this cannot be made publicly available.

⁹² OECD, [Best Practices for Budget Transparency](#) (2002)

3. **There should be a clear understanding of how the programs relate to the multiple budget functions.** It remains unclear to analysts how do the development programs in the OGE (*e.g., Fight Against Major Endemic Diseases*) relate to the function and sub-functions (*e.g., Public Health Services*) within the same field/ sector.
4. **Restructuring of performance indicators should be explained.** Although performance indicators in the health programs are fairly consistent with PDN 2018 – 2022. Some performance indicators do change, especially in recent years. These changes should be reviewed and explained in the upcoming CGE 2022.

Another field that might be developed, increasing engagement, would be to involve the community in drafting policies and budget allocation preferences.

6.2.8. Increase Expenditure on Routine Vaccination and Perform a Financial Analysis on Cost-Effectiveness

Immunization against measles in 94 low- and middle-income countries showed an estimated return-on-investment of US\$ 76.5 for every US\$ 1 invested in vaccination⁹³. This means that routine immunization does not only reduce child mortality, but it is also a sound long-term investment plan.

Furthermore, as discussed in Chapter 4.2. Angola's total expenditure on routine immunization (US\$ 28.9 per surviving infant) is significantly below that of the WHO African region on average (US\$ 41 per surviving infant) as well as the global average (US\$ 68 per surviving infant).

For both these reasons, the government should consider an increase in spending on routine vaccination. This has strong budgetary implications given that procurement needs to be done at a larger scale but is prevented by the limited predictability and the monthly allocation of the budget.

The major issue facing routine immunization identified was vaccine stock shortages at a regional level. This means that, although there normally is available stock at the national level, there are logistic challenges that result in regional shortages at municipal healthcare units. These challenges include delayed communications on low stock and transportation costs, especially when considering hard-to-reach communities.

The COVID-19 pandemic has allowed the country to tackle some of these challenges and heavily strengthen its cold-chain, through investment from international partners. However, there is still room to grow. Especially, in rural regions, where immunization

⁹³ So Yoon Sim et al. [Return On Investment From Immunization Against 10 Pathogens In 94 Low- And Middle-Income Countries, 2011–30](#) (2020)

of multiple children is sometimes concentrated in specific days of the week in order to maximize the number of doses given per vaccine vial. It is important to note though that every Province is now equipped with ultracold freezers.

The challenges described above can be tackled by greater funding, but this funding must be thoroughly guided by a coherent strategy. The National Vaccination Program is currently working on updating the country's National Immunization Strategy, a project that was put on hold in 2020 due to the COVID-19 pandemic. We incentivize this initiative and further highlight that such a strategy should be built upon the 6 priorities defined by the Immunization Agenda for 2030⁹⁴:

- I. Commitment and Demand
- II. Coverage and Equity
- III. Life Course and Integration
- IV. Outbreaks and Emergencies
- V. Supply and Sustainability
- VI. Research and Innovation

Within this strategy, funding should be also channeled towards mobile immunization units to target difficult-to-reach communities, increasing the frequency of door-to-door campaigns like those established for Polio campaigns and the establishment of automatic mechanisms that would alert parents on vaccination deadlines and appointments via social media platforms and mobile communication apps (e.g., WhatsApp). Successful pilot programs of mobile alerts were implemented in Luanda during the pandemic and should be further expanded to the other vaccines and Provinces. Vitamin A supplementation and deworming should be annexed to these initiatives too.

Although regional shortages are the main challenge identified, there are also occasional instances of a national stock shortages — this was the case in late 2021 and early 2022, where there was a general shortage of vaccines in the country. The problem here lies with the unpredictability of available funds, on a monthly basis, for the purchase of vaccines (and medicines in general), which limits the capability of MINSA to acquire vaccines in bulk. Long-term financing needs should be highlighted in the National Immunization Strategy too in order to address this issue.

Concerns over vaccine shortages happening over the last few years could also be addressed by an adequate stockpiling policy, linked to better procurement strategy, as already mentioned above.

Furthermore, the National Vaccination Program is also seeking to perform a financial analysis on cost-effectiveness. We encourage these efforts, which are tremendously

⁹⁴ [Immunization Agenda 2030](#)

important to support results-based budgeting strategies and maximize the funding allocated to immunization.

Ultimately, it is important for Angola to build a robust routine immunization platform so that, in the near future, it can begin to introduce new vaccines, possibly including the recommended HPV vaccine — which has been shown to decrease the prevalence of cervical-cancer derived from HPV infection by 83% among girls aged 13 to 19 after 5 to 8 years of its introduction. But also, the RTS,S/AS01 malaria vaccine which is currently being rolled out in pilot programs in Ghana, Kenya and Malawi⁹⁵. The results from these programs have been successful enough to lead the WHO to recommend the expansion of this trial on October 2021, and UNICEF to secure a contract for the first ever supply of a malaria vaccine to GSK with a value of up to US\$ 170 million.

⁹⁵ WHO, [Over 1 million African children protected by first malaria vaccine](#) (2022)

Annexes

Annex I. Performance Indicator of Health and Nutrition Programs

Improvement of Medical and Medication Assistance

Year	2020		2021		2022	
Indicator	Objective	Result	Obj.	Result	Obj.	Result
Municipalities with Primary Health Care Units, Including Mobile Teams with Essential Services and Care (%)	45%	51%	50%	51%	60%	—
Population with Access to Health Services (%)	70%	60%	75%	60%	80%	—
Municipal Health Units with a Basic Package of Essential Care and Medication (%)	50%	100%	55%	100%	60%	—
Municipal Teams that Conduct Analysis of the Municipal Health Situation (Asis) (%)	80%	92%	90%	58%	100%	—
Municipalities that Conduct Visits to Difficult-to-Receive Populations with Mobile Health Teams (%)	85%	51%	90%	37%	—	—
New Beds in Hospitals (No.)	500	5581	1240	1634	380	—
Provinces Where Hemodialysis Services Exist (No.)	1	2	1	1	1	—
Increase Supply of Health Professionals (No.)	0	7000	0	7000	—	—
Health Units With Patient Support Offices (%)	70%	0%	80%	0%	90%	—
Patient Evacuations Abroad (%)	70%	43%	60%	39%	50%	—
Drug Deposits Actually in Operation (%)	85%	100%	90%	100%	100%	—
Country facilities with essential drugs, medical devices and other health products (%)	70%	100%	80%	100%	80%	—
Referred Drug Addicts Accompanied by Rehabilitation and Drug Addiction Centers (%)	12%	4%	16%	9%	—	—

Year	2022	2023
Indicator	Budget	Budget
Municipalities with Primary Health Care Units, Including Mobile Teams with Essential Services and Care (%)	51 354	57 604
Population with Access to Health Services (%)	27	43 452
Municipal Health Units with a Basic Package of Essential Care and Medication (%)	10 289	12 421
Municipal Teams that Conduct Analysis of the Municipal Health Situation (Asis) (%)	645	603
New Beds in Hospitals (No.)	36 182	64 955
Provinces Where Hemodialysis Services Exist (No.)	12 158	1 138
Health Units with Patient Support Offices (%)	22 707	31 610
Patient Evacuations Abroad (%)	300	2 640
Drug Deposits Actually in Operation (%)	718	5 585
Country facilities with essential drugs, medical devices and other health products (%)	10 527	23 757
Referred Drug Addicts Accompanied by Rehabilitation and Drug Addiction Centers (%)	149	276

Improvement of Maternal and Child Health and Nutrition

Year	2018		2019		2020		2021		2022	
Indicator	Objective	Result	Obj.	Result	Obj.	Result	Obj.	Result	Obj.	Result
Institutional Maternal Mortality Ratio	226	384	219	170	213	290	206	187	199	—
Pregnant woman with 4th antenatal visit (%)	63	52	65	34	67%	26%	71%	38%	—	—
Institutional births assisted by qualified personnel (%)	51%	25%	53%	34%	55%	21%	57%	29%	60%	—
Health Units with comprehensive childcare consultation (%)	20%	25%	30%	25%	40%	93%	50%	93%	60%	—
Health Units offering at least 3 modern methods of family planning (%)	30%	30%	40%	40%	50%	40%	60%	40%	70%	—
Measles immunization coverage (%)	65%	77%	75%	76%	80%	54%	85%	59%	0%	—
Pentavalent immunization coverage (%)	55%	83%	65%	51%	75%	60%	80%	63%	90%	—
Municipalities with integrated adolescent care services (%)	15%	10%	20%	10%	25%	93%	30%	93%	0%	—
Children under 5 years with vitamin A supplementation (%)	30%	28%	40%	40%	30%	41%	40%	21%	0%	—
Under-five Malnutrition Rate (%)	17%	0%	15%	15%	0%	0%	0%	0%	9%	—

Year	2022	2023
Indicator	Budget	Budget
Institutional Maternal Mortality Ratio	6 321	20 199
Pregnant woman with 4th antenatal visit (%)		316
Institutional births assisted by qualified personnel (%)	546	5 331
Health Units with comprehensive childcare consultation (%)	4 178	28 403
Health Units offering at least 3 modern methods of family planning (%)	314	1 651
Measles immunization coverage (%)		
Pentavalent immunization coverage (%)	2 972	1 451
Municipalities with integrated adolescent care services (%)		3 174
Children under 5 years with vitamin A supplementation (%)		
Under-five Malnutrition Rate (%)	1 521	4 738

Fight Against Major Endemic Diseases Through Health Determinants Approach

Year	2020		2021		2022	
	Obj.	Result	Obj.	Result	Obj.	Result
Malaria Mortality Rate (%)	25%	34%	20%	42%	10%	—
Pregnant Women Who Receive At Least 4 TIP Doses (%)	33%	37%	45%	23%	—	—
Municipalities with Integrated Vector Control Teams (%)	60%	65%	70%	72%	—	—
HIV/AIDS Mortality Rate (%)	—	—	—	—	13%	—
Tuberculosis Treatment Success Rate (%)	75%	70%	80%	76%	85%	—
Leprosy Patients With Multidrug Treatment (MDT) (%)	80%	100%	82%	100%	85%	—
Cases of Trypanosomiasis Diagnosed and Treated (%)	60%	47%	75%	37%	—	—
Urinary and Intestinal Infections Due to Schistosomiasis (%)	15%	6%	11%	9%	—	—
Health units with screening and follow-up of patients with arterial hypertension and diabetes (%)	15%	6%	35%	30%	50%	—
Primary Level Health Units with Mental Health Services (%)	15%	9%	20%	7%	—	—
Municipalities with Operational Public Health Emergency Response Teams (%)	40%	100%	50%	100%	—	—
Mother-to-Child HIV Transmission Rate (%)	—	—	—	—	—	—

Year	2022	2023
	Budget	Budget
Malaria Mortality Rate (%)	15 554	7 500
Pregnant Women Who Receive At Least 4 TIP Doses (%)	—	—
Municipalities with Integrated Vector Control Teams (%)	—	—
HIV/AIDS Mortality Rate (%)	2 517	2 476
Tuberculosis Treatment Success Rate (%)	52 840	24 973
Leprosy Patients With Multidrug Treatment (MDT) (%)	158	80
Cases of Trypanosomiasis Diagnosed and Treated (%)	—	—
Urinary and Intestinal Infections Due to Schistosomiasis (%)	—	—
Health units with screening and follow-up of patients with arterial hypertension and diabetes (%)	1 507	956
Primary Level Health Units with Mental Health Services (%)	—	—
Municipalities with Operational Public Health Emergency Response Teams (%)	—	—
Mother-to-Child HIV Transmission Rate (%)	—	300
	15 554	7 500

Strengthening of the Health Information System and Development of Health Research

Year	2020		2021		2022	
Indicator	Obj.	Result	Obj.	Result	Obj.	Result
Health entities enrolled in the Digital Health Information System (DHIS2; %)	90%	100%	92%	100%	95%	—
Municipalities with the Vid-R System Implemented (%)	90%	100%	92%	100%	95%	—
Number of scientific studies published (no.)	7	6	6	2	—	—

Year	2022	2023
Indicator	Budget	Budget
Health entities enrolled in the Digital Health Information System (DHIS2; %)	458	2 400
Municipalities with the Vid-R System Implemented (%)	552	2 198
Number of scientific studies published (no.)	—	—

Annex II. Currency Exchange Rates

For the purposes of converting American dollars to kwanzas (and vice versa), an average annual exchange rate was applied⁹⁶.

2020: 1 USD = 578.4 AOA

2021: 1 USD = 637.6 AOA

An exception was made for values referring to the **2022/23** biennium, for which the current (01/04/2023) exchange rate according to Google Finance was used (1 USD = 507.5 AOA).

The use of an average rate, although not an accurate method of comparison, has an associated error which was considered negligible for the purposes of this report. For expenses incurred over the two years, the rate applied reflected the average of both.

⁹⁶ Statista, [Annual Average Exchange Rate of Angolan Kwanza to US Dollar from 2012 to 2021](#).



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