



The human resources policy of the of Health Ministry in Angola - from current practice to the desired praxis

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Abstract: Poor countries assume dramatic indicators regarding the institutional capacity in the health sector. In this sense, planning and good management of human resources for health it is essential to solve problems linked to this issue under study. In the present study we focus on the analysis of Human Resources policy of the Department of Health in Angola because there is a substantial difference between the desired and actual practice praxis. Is observed in the study that is taking great strides to improve human resources for health in Angola, however there is a lot to improve. The path must be based on overcoming the challenges related to HR issues in health care in order to increase the coverage and attachment of professional teams to ensure the delivery of health services appropriately and equitably; guarantee competences and skills for the workforce in health; increase the performance of the professionals in the defined objectives and strengthening the capacity for planning and management of human resources in the health sector^[1].

Keywords: Angolan health, human resources policy, health management, motivation, communication, resilience, moving professionals

I. Introduction

In the particular field of health, the World Health Organization (WHO) declared that "health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or disability [2]. This definition somehow contemplates the possibility of differentiating between positive and negative health and their approach invites to a reflection that is still needed. The same authors state that the World Federation for Mental Health in 1962 defined health as the best state possible with the existing conditions. Still claim that in 1986, in Ottawa, the first official meeting of the WHO health promotion concluded that "health is a resource for daily life, not the objective of living. It is a positive concept emphasizing social and personal resources, as well as physical capacities"[2].

In this sense there is an emphasis on training health professionals in Angola, and after independence, the country had only the of nurses trained on primary and secondary level. Were formed the first 6 nurses with a Bachelor's Degree in Nursing School (ESSE), current ISCISA of Agostinho Neto University in 2001. For example, given the expansion of higher education in Angola and increment of courses healthcare, higher education in nursing grown, the course currently being ministered in public institutions in 11 provinces, with the degree of Bachelor. [3]

With regard to the management of Human Resources (HR) in Angola, the Ministry of Health of Angola, called MINSA, is the organ of the central administration state that executes, oversees and supervises the national health policy. Fits the this Ministry (1) prepare and propose a national health policy; (2) ensuring their correct implementation, monitoring and periodic review; (3) promote the health development of the country in coordination with national partners and related sectors of the national and international communities; (4) promoting the monitoring and combating endemic-epidemic diseases; (5) promote the health of the general population, in particular of vulnerable populations, especially children and women, to take measures necessary to ensure the fairness and accessibility to health care; (6) develop programs to solve specific health problems and submit them for approval by the Council of Ministers; (7) promote the development of human resources, participating in the planning, training and monitoring the performance of health professions in collaboration with other relevant institutions; (8) coordinate and guide the provision of health care to the national health system level, taking measures for the constant increase of their quality; (9) promoting the lifestyle, the environment and healthy nutrition, disseminating knowledge for positive behavior modification; (10) ensuring the implementation of national and international health legislation and other legislation of interest to public health; (11) promote and coordinate social and resource for the development of health mobilization; (12) Promote and implement appropriate health technologies, particularly in the areas of infrastructure, pharmaceutical, medical-surgical and non-medical means; (13) issuing the authorization or the withdrawal of the national pharmaceutical market, pharmaceutical and herbal; (14) encourage research in the area of health and their use for improving the health status of the population; (15) promote, in partnership with other agencies, legal medicine; and (16) perform other functions as may be affected. [4]

In the present study, we aim, through intensive, reliable literature review, questioning the human resources policy of the Ministry of Health in Angola are in practice what the studies and law claiming to be. However, as can be seen below in the various studies and information analyzed, there is a difference between the policy of Human Resources (HR) of the Ministry of Health of Angola and the desired actual praxis.

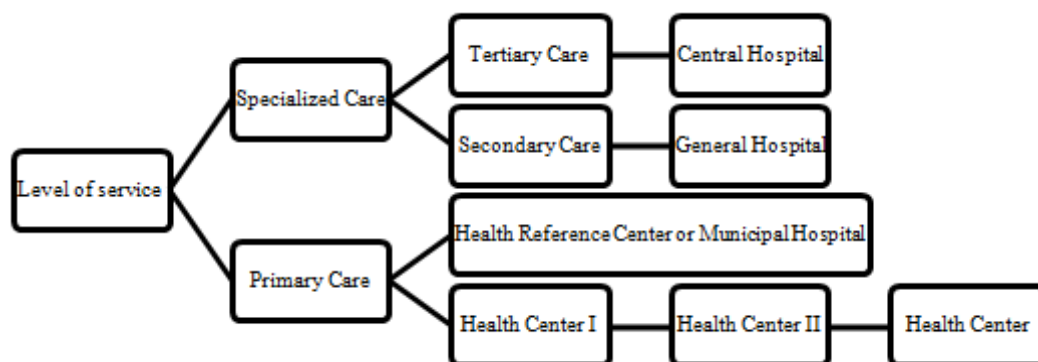
II. Angola and the healthcare system

Angola is situated in southern Africa, has an area of 700km² 1,246 and a coastline of 1.600km from north to south. Its population is estimated at 16.500.00 habitants, distributed in 18 provinces; 164 districts and 532 communes (parishes) mostly young. The economic situation is characterized by high levels of economic growth since 2002, with the end of the armed conflict. Its economy is dependent on oil (55% GDP) and diamonds. Its population is mostly poor, with 61% of the population living below the poverty line, 26% of the population lives in extreme poverty. The country is located in 160th place in accordance with the International Diploma in Humanitarian Assistance (IDHA), the set of 173 countries and the average life expectancy is 46 years. The Angolan epidemiological picture is dominated by transmitted diseases such as malaria, diarrheal diseases, acute respiratory infections, tuberculosis, trypanosomiasis (sleeping sickness), vaccine-preventable diseases such as measles and tetanus, and others. Malaria remains the leading cause of death and the prevalence of HIV Angola is less than 5%. From 1975 to 1992, the National Health System (NHS) Angola, was based on the principles of universality and gratuitousness of primary health care. Since 1992, with the approval of 21-B/92 Law, Law of the NHS, the Angolan state no longer has exclusivity providing of health services and admits the share of users, with payment of prescription charges. Currently, health care is provided by the Private Sector. In terms of infrastructures, the network of health care consists of 1,721 health units, with eight central hospitals, 32 provincial hospitals, 228 district hospitals and 1,453 clinics. At the moment, Angola has 995 Angolan doctors and 1,273 expatriate doctors, totaling 2,268 medical doctors. In terms of medications, stocks are constant breaking due to poor planning and purchases dispersed by various companies not affected to the Ministry of Health [5].

Also, Connor, Averbug and Miralles [6] note that the coverage of basic health services increased by 30-42% since 2005. Public financing of primary care health units grew more than any other category. The geographical access increases through the renovation and construction of health centers, in many cases built based on provincial health maps and some experiences using private services to reach population. The quality of the services is still below expectations due to issues related to human resources, lack of essential goods and irregular financing of recurrent costs.

In Angola, was inherited from the colonial health system serve almost exclusively the settlers and was not adequate to meet the health needs of the local population. The long war that started after independence has stopped the development of an appropriate system of health until a few years ago, when the war finally ended. After decades of destruction, in the first years of peace there was a rush to invest in the health sector. This investment not necessarily agreed with the priorities of the population health, because it was done without much information or planning. In recent years, major developments in the government of Angola and donations support began pulling the health system in Angola for a more informed and systematic strategy, currently being organized in the Health service as showed in Figure [6]:

Figure 1: Levels of Health Care in Angola



As can be observed, the system of providing health care is divided among three levels of health care, based on the strategy of primary health care. The first level or primary health care, represented by the posts, health centers, district hospitals, nursing stations and doctors' offices, is the first point of contact of the population with the health system. The secondary or intermediate level, represented by provincial and general hospitals, is the reference level for the units of the first level. The tertiary or national level, represented by differentiated and specialized hospitals, is the reference level for health facilities in the secondary level. The provision of health care is taken by the public, private and traditional medicine industries. [7]

III. The distribution of health workers in Angola

Health care in Angola are provided mainly by the public sector including the National Health Service (NHS), the health services of the Angolan Armed Forces (FAA) and the Ministry of Interior. It also includes public companies, such as SONANGOL, EDIAMA, among others. In general terms, the public sector is the main provider of health care at the national level. Despite the universality principle that guides the NHS, the system lacks the capacity and structure that allows widespread access of the population to health care. However, increasingly, the private sector has been participating in the market. With the approval of the Law on the National Health System (Law 21-B/92), is permitted to private sector provision of health care, having been established, similarly, the notion of sharing of users through user fees. The private sector, although important, is confined to major urban centers of the country. Prices (not regulated) health care limits the accessibility of the population to the lucrative private sector. Since 2005, all major companies provide some type of health coverage for their employees, whether in clinics, outpatient own company or independent contractors hospital facilities. This coverage extends to dependents of employees and even to employees of third sector. [8]

The time of the armed conflict in Angola (1997-2001), the international community has an important role in health financing, particularly in the purchase of medicines and vaccines. After this period, support turned to training and the NHS to combat endemic diseases such as HIV/AIDS, malaria and tuberculosis. Table 1 illustrates what's new since 2005 in health financing. Angola is in a favorable position relative to sub-Saharan Africa region especially with regard to several important indicators relating to health financing. [8]

Table 1: Health Financing in Angola since 2005 [9]

2005 (2000-2005)	2010(2003-2010)
Limited public resources to primary care (25% of total expenditure on health in 2002)	Public expenditure on primary care grew 415% to 33% of total public spending on health (2005)
70-80% budget implementation (2002-02)	62-75% budget implementation (2003-05)
Infrastructure investments without any criteria (2005)	Infrastructure investments driven "health maps" detailed 11 provinces (2008-2010)
Government expenditure on health is only 4-6% of total expenditure (2000-2002)	Government spent on health only 4.7% of total expenditures (2003-06)
Provinces administer budgets of operating expenses at the level of primary care (2005)	Transition of the budgetary management of operational expenses for municipal primary care levels (2008-10)
Patients pay rate of use in some of the units of primary care (2005)	Eliminated the payment of the use in primary care units (2008)
No plan for public or private health insurance (2005)	Emergence of private health insurance plans (2009)

Marchi et al. [10] reported that Angola is one of the African countries that has the highest rates of mortality and devastating shortage of human resources in health care, including nursing. The World Health Organization encourages and implements technical cooperation initiatives for the training and development of human resources in health and education, aiming at the development of African countries. These authors developed a study that aimed to identify the perceptions of nurses bound to Nursing Training Schools regarding the challenges for nursing education in Angola.

According to the article by Oliveira and Artmman [11], the most important endemic diseases in Angola are malaria, tuberculosis, HIV, leprosy, among others, and has a high infant mortality rate. From the point of view of HR, there is a high concentration of nurses and other health professionals in capital, representing an asymmetry in the distribution of professionals in the Angolan provinces. With regard to health care services, is a degraded system, a result of years we've been at war and under-investment in this area. The authors suggest, from the point of view of the efforts to improve the quality there is a better allocation of human resources, which is developed relevant and appropriate to this country legislation that improves the health network, which motivate the workers, who if wages increase, which can invest in public transport (for better access to health services), there is investment and greater investment in health. Thus, "Despite the still weak performance of health systems in Africa, the gradual implementation of regionalization, which consider the realities and political-administrative, epidemiological, economic, cultural, managerial, cognitive local circumstances, according to the experiments analyzed, including African countries could represent a suitable strategy for improving access to health care, particularly for economically disadvantaged groups. In addition, it could strengthen the decentralization process underway.

The Report of the great inequalities in Health Services in Angola [12] points out that the distribution of skilled health personnel in Angola be quite uneven. Most health facilities in Uige has neither a general practitioner or a specialist nurse. All health centers in Luanda have visited a lab technician and 80% have a pharmacist. In Uige, only 35% had a laboratory technician and 30% had a pharmacist. In fact, all health facilities need a stethoscope

and a thermometer to assist in the diagnosis of diseases, and the premises in Luanda there is this basic equipment, while 30% of facilities in Uíge not have a single stethoscope and 15% did not have a thermometer. Medicines and vaccines seem to miss, both in Luanda and Uíge, but again, the situation is considerably worse in Uíge. In turn, the antibiotics were found in stock at 75% of facilities in Luanda, but only half of the facilities in Uíge. Similarly, anti malarial drugs were depleted 20% of the units in Luanda, while the rate of stock-out was 35% in the units Uíge. The stock-out rates were also high for essential childhood vaccines. Finally, 55% of health facilities in Uíge did not have all these vaccines in storage, while in Luanda the percentage was 25%.

In the study developed by Oliveira and Artmann [11], the authors conclude that the conditions referred by doctors for accepting to work in the cities of the interior, for a time not exceeding two years, and influence the turnover and retention of professionals in the areas rural are: (a) professional factors - nature of work, job satisfaction, working conditions, compensation, opportunities for professional growth, physical accommodations, among others; (b) social factors - personal and family characteristics; (c) External factors - related to the community and its geographical location. The problem of inequitable distribution of health RH, leading to low supply of services in areas far from urban areas is a phenomenon of world order, despite the specificities related to different realities. In this sense, different strategies have been implemented by different countries in an attempt to guarantee access to health services for people in rural and remote areas. The authors analyzed some strategies and it is considered that the experience of the Work Programme Internalization of Health (PITS) of Brazil is the most interesting for the reality of Cabinda as it combines aspects of intrinsic and extrinsic motivation should be adjusted to the objectives and local economic and socio-cultural specificities. Extrinsic factors refer to wages, social benefits, type of leadership or supervision, physical working conditions, organizational policies, climate of relations between management and individual and internal regulations. Intrinsic factors are related to the content of the post or nature of the tasks which the individual performs and encompass feelings of self-fulfillment, personal growth and professional recognition.

A. How prompt professionals to move to other areas of Angola?

Currently organizations go through a period of crisis worldwide, communication and motivation play a key role within organizations, with a view to the involvement of employees and improvement of individual performance to the achievement of organizational objectives. It is essential to motivate the employee and “break paradigms and transform the company into a place where the employee feels valued is the first step”. In fact, companies should create and maintain the internal environment in which people can become fully involved in order to achieve the organization's objectives. Thus, it is expected that with this principle exists communication between different levels of the organization, as well as increased motivation of employees to the organization's goals are met, taking into account the needs of all [13]. Moreira and Soares claim that there must be involvement of people: people from all levels of the organization are its essence and its involvement enables their abilities and skills are used to the company. This principle leads to increased commitment and motivation of employees, as well as their creativity. It is expected a greater understanding on the part of employees about how important the contribution of each individual to the organization.

As refers Pereira and Favero [14] the day-to-day practice of health, the activities require highly interdependent, and the motivation emerges as a fundamental aspect in the search for greater efficiency and hence higher quality of care in health provided, coupled with worker satisfaction. Indeed, institutions should create and maintain the internal environment in which people can become fully involved in order to achieve the organization's goals.

Another factor is the importance of communication; communication, internal and external, has a great relevance, strengthening the bond between the individual and organizational goals [15]. Valladares and Son mention that “the open and institutionalized communication between organizational members in their different areas of expertise or strategic business units, allows working channels of communication embodying horizontal flows of knowledge. It is worth mentioning that the existence of communication channels enhances learning. Thus, should be encouraged not only by technological or formal means of information exchange, but also through informal contacts between people”.

To Barlach, Limongi, Franca and Malvezzi [16] “the term resilience in the context of work in organizations refers to the existence - or construction - adaptive resources in order to preserve the healthy relationship between humans and their work in changing environment, permeated by numerous forms of ruptures”.

Thus, for the Angolan health professionals, professional resilience produces self-protection capability, risk taking and proceed with the reflective knowledge of self. [17]

Finally, the technical expertise of professional undergo a thorough knowledge in a specific field of activity of health, taking into account the human responses to the processes of life and health problems, which show high levels of clinical judgment and decision making, translated a set of specialized expertise covering a field of intervention. [18]

IV. Conclusion

The new Angolan health professionals usually begin their practice in acute care in hospitals, where his work is characterized by time constraints with high security risks for patients, and layers of complexity, and difficult

environments. The retention of experienced professionals is central to patient safety that because young professionals spend a significant amount of time to learn their place in the social structure. With positive experiences, they begin to feel more competent with skills and relationships and become increasingly aware of discrepancies between their professional ideas and their actual experiences in the workplace. Thus, for health professionals, professional resilience produces self-protection capability, risk taking and proceed with the reflective knowledge of self. [17]

In summary, organizational communication and motivation of health of any Angolan institution will have greater chances of getting desired results without taking into account human capital as having a key role in the success of strategic planning. Thus, possible deviations that hinder the achievement of established goals will be avoided. Organizational communication allows you to create a link between the Angolan institutions, take them to integrate with the other and this is only possible through communication and communication. It should be understood that the MoH of Angola must employ the various resources dedicated communication to achieve their goals and understand certain situations, since he must know how to think, act and needs of its employees (internal and external). Similarly, the policy of the MoH should play an important role in promoting more advanced cultures of quality at all levels of the organization and lead the process of change, both in human resources and strategy, as well as promote its philosophy of management, set goals and create an organizational structure capable of achieving the proposed objectives in Angolan health.

References

- [1] C. Pierantoni, T. Varella and T. França, “Recursos humanos e gestão do trabalho em saúde: da teoria para a prática”, Observatório de Recursos Humanos em Saúde no Brasil. Estudos e Análises – Vol. 2, 51-88, in press.
- [2] C. Vázquez and C. Hervás. *La Ciencia del Bienestar - Fundamentos de una Psicología Positiva*. Madrid: Alianza Editorial, 2009.
- [3] E. Silva, Universidade Agostinho Neto. *Quo vadis?*, Luanda: Kilombelombe, 2012.
- [4] Ministério da Saúde de Angola, <http://www.minsa.gov.ao/Institucionais/Atribuicoes.aspx>
- [5] A. Queza, “Sistema de Saúde em Angola: Uma Proposta à Luz da Reforma do Serviço Nacional de Saúde em Portugal”, Tese de Mestrado Integrado em Medicina, Universidade do Porto, Faculdade de Medicina, 2010, p.3.
- [6] C. Connor, D. Averbug and M. Miralles, “Angola Health System Assessment 2010”. Bethesda, MD: Health Systems 20/20, Abt Associates Inc.
- [7] OMS, “Estratégia de Cooperação, Resumo”, http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_angola_po.pdf
- [8] C. Simões, J. Pinho, M. Cabral., and P. Veiga, *Internacionalização do Setor da Saúde Nacional. Mercados em Análise: ANGOLA, aicep Portugal Global, Caderno Suplementar 2, 2010*, <http://www.portugalglobal.pt/pt/biblioteca/livriadiadigital/cadernoangola.pdf>
- [9] USAID, “President’s malaria initiative -Malaria Operational Plan — FY2011 Angola”, 2010a, http://www.pmi.gov/countries/mops/fy11/angola_mop-fy11.pdf [último acesso: junho 2012].
- [10] L. Marchi-Alves, C. Aventura, M. Trevizan, A. Mazzo, S. Godoy and I. Mendes, “Challenges for nursing education in Angola: the perception of nurse leaders affiliated with professional education institutions”, *Human Resources for Health*, 2013, pp. 11-33.
- [11] M. Oliveira and E. Artmann, Características da força de trabalho médica na Província de Cabinda, Angola. *Cad. Saúde Pública* [online]. 2009, vol.25, n.3, pp. 540-550, <http://dx.doi.org/10.1590/S0102-311X2009000300009>.
- [12] O. Maestad, M. Frøystad and N. Villamil, “Grandes Desigualdades Regionais nos Serviços de Saúde em Angola”, *Angola Brief*, may 2011, vol.1, n.º 4.
- [13] M. Moreira and C. Soares, C., *Motivando e retendo talentos nas organizações*. disponível no site https://www.google.pt/url?sa=t&rc=t&q=&esrc=s&source=web&cd=1&cad=rja&ved=0CDEQFjAA&url=http%3A%2F%2Fwww.aedb.br%2Fseget%2Fartigos04%2F166_Motivando%2520e%2520Retendo%2520Talentos%2520nas%2520Organizacoes-SEGET-RESENDE.doc&ei=MTZcUvzqN-Sv7Qa0n4D4CA&usq=AFQjCNF--B8k4haTaW6BQ4TOEnCIYC3HYA&sig2=pWnnD6gbTGfLdctKfBgAw&bvm=bv.53899372,d.ZGU
- [14] M. Pereira and N. Fávero, “A motivação no trabalho de equipe de enfermagem”. *Revista Latino-Americana de Enfermagem*, vol. 9, n.º 4, 2001, pp-7-12.
- [15] A. Valladares and J. Filho, “Gestão contemporânea de negócios: dimensões para análise das práticas gerenciais à luz da aprendizagem e da participação organizacionais”. *Revista FAE*, vol. 6. n.º 2, 2013, pp.85-95.
- [16] L. Barlach, A. Limongi-Franca, and S. Malvezzi. “The concept of resilience applied to work in organizations”. *Interamerican Journal of Psychology* vol. 42, n.º 1, 2008, pp. 101-112. ISSN 0034-9690.
- [17] H. Hodges, A. Keeley and P. Troyan, “Professional Resilience in Baccalaureate-Prepared Acute Care Nurses: FIRST STEPS. *Nursing Education Perspectives*, vol. 29, n.º 2, 2008, pp. 80-89.
- [18] Ordem dos Enfermeiros, Código Deontológico (Inserido no Estatuto da OE republicado como anexo pela Lei n.º 111/2009 de 16 de setembro), 2010, p.2, <http://www.ordemenfermeiros.pt/legislacao/Documents/LegislacaoOE/CodigoDeontologico.pdf>