

Healthy Support? Sidas Support to the Health Sector in Angola 1977–2006

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Preface

The Swedish support to the Health Sector in Angola started soon after Angola's independence in 1975. Some three decades later it was the last Sida Programme to be phased out, in March 2006.

The total amount disbursed during these years was MSEK 667 and included support to primary health care, infectious diseases programmes, essential drugs, and maternal- and child health. During most of this time Angola has been ravaged by a devastating civil war. The conflict led to the displacement of almost one third of the population, the overcrowding of the capital Luanda and unbearable human suffering.

This study analyzes the motives and methods of the Swedish cooperation and lessons learnt from supporting the health sector over such a long period of time and under difficult conditions.

Angola has some of the worst health indicators in the world, with alarmingly high maternal- and child mortality rates. There are a number of contributing factors, but the main one has no doubt been the war. It has never been possible to implement the health programmes to their full extent due to the conflict.

The cooperation would also have benefitted from more preparatory studies when designing the support and more systematic learning and follow-up from the studies and evaluations actually carried out. Sidas initially defined objective to help build a nationwide Public Health system was never achieved. Nevertheless some important components of such a system have developed and are working efficiently. A number of the programmes that have received support from Sida are still performing more or less according to plans. Another positive development is in the area of institutional capacity, where various institutions involved in the Angolan-Swedish cooperation have been strengthened.

This study was initiated by Sida's Health Division at the Department for Democracy and Social Development in cooperation with the Embassy of Sweden in Luanda and carried out by the Institute of Public Management (IPM). It was later complemented by an evaluation of the last agreement in the Angolan health sector 2004–2006 entitled "Phasing-out Swedish Health Support in Luanda, Angola" (Sida Evaluation 2008:03).



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Acronyms and abbreviations

BCG	Vaccine against Tuberculosis (Bacille de Calmette et Guérin)
CAOL	Coordenação de Atendimento Obstétrico em Luanda (Coordination of obstetric treatment in Luanda)
CAPEL	Coordenação de Atendimento Pediátrico de Luanda (Coordination of Paediatric Care in Luanda)
CNS	Centro Nacional de Sangue (National Blood Centre)
CRC	Convention on the Rights of the Child
CUAMM	Collegio Universitario Aspiranti Medici Missionari
DN	Dagens Nyheter (Daily News), Swedish newspaper
DOTS	Directly Observed Treatment Short-Course
DTP	Vaccine against Diphtheria, Pertussis (Whooping Cough), Tetanus
EC	European Commission
EDP	Essential Drugs Programme
ELISA	Enzyme-linked Immunosorbent Assay (serum/blood test)
EPI	Extended Programme of Immunization
ETPSL	Escola Técnica Profissional de Saúde de Luanda (Luanda Technical Vocational Health School)
EU	European Union
FNLA	Frente Nacional para a Libertação de Angola (National Front for Angolan Liberation)
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
ICH	International Child Health Unit
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
JMPLA	Juventude do MPLA (MPLA's Youth Organization)
Kz	Kwanza, Angolan monetary unit
MCH	Maternal and Child Health
MINSa	Ministério da Saúde (Ministry of Health)
MMRi	Maternal Mortality Ratio-institutional/intrahospital
MoH	Ministry of Health
MPLA	Movimento Popular de Libertação de Angola (Popular Movement for Angolan Liberation)
MSEK	Million Swedish Crowns
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organization

NNT	Neonatal Tetanus
OAU	Organization of African Unity
OCHA	UN Office for the Coordination of Humanitarian Affairs
OMA	Organização das Mulheres de Angola (Angolan Women's Organization)
PHC	Primary Health Care
SBL	Statens Bakteriologiska Laboratorium (National Bacteriological Laboratory)
SEK	Swedish Crown, Swedish monetary unit
Sida	Swedish International Development Cooperation Agency
STD	Sexually Transmitted Disease
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNITA	União Nacional para a Independência Total de Angola (National Union for Full Independence for Angola)
UNTA	União Nacional dos Trabalhadores Angolanos (Angolan Workers' Union)
WFP	World Food Programme
WHO	World Health Organization

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Many thanks are due to all those who gave of their time to meet with us in Luanda, answer our questions and discuss their experiences of the Swedish-Angolan cooperation and the history of their programmes. This report was also enriched through the lively discussions during a seminar about the Swedish-Angolan cooperation held in Luanda in November 2006. We are, thus, very grateful for all contributions during the whole process of this study.

Special thanks go to Mrs. Marinela Lima, who was of invaluable help making all the contacts and organizing our day-to-day programme in Luanda, so that we could meet with so many people in a short time.

We naturally want to mention the group of Swedes we have talked to. They have in different capacities participated from the very beginning to the last phase of the cooperation. Many of them have been helpful with information and documentation from different periods and have shared their experiences and ideas about progress as well as setbacks from their point of view. And last, but not least: Without the collaboration of Sida's archive staff we would not have been able to find all the material needed to make this study.

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Executive summary

Introduction

The Swedish support to Angola started before the country had obtained its Independence, and one of the main areas of support was the health sector. This Programme started in 1977 and was the last Sida Programme to be phased out in March 2006.

This study, commissioned by Sida, started in June 2006 and was finalized in November with a seminar in Luanda. The evaluation describes the historical background of the cooperation from the preparation of the first agreement at the end of the 1970's, the changes over time and the constraints and set-backs caused by lack of staff and management capacity, and, above all, the protracted war. The Angolan people finally got a durable peace in 2002.

Sida's support over time

After the first request from the Angolan Ministry of Health (MoH), Sida decided to help build up the Primary Health Care (PHC) services. From the beginning the selected areas were development of PHC (implemented bilaterally), immunization, nutrition and water (implemented through UNICEF), the malaria programme (implemented through WHO) and transport through importation of vehicles (bilateral). The first agreement 1979–82 amounted to 41 MSEK, but Angola could only spend half of the budget. In spite of this, the amount was increased in the subsequent agreement, and the largest proportion of the budget was allocated to the programme for control and treatment of endemic diseases, which needed vehicles and sophisticated equipment, while the “softer” PHC components spent less money.

In time, the Programme expanded and became more complex. To strengthen management and coordination, the Programme had to include Technical Assistance (TA) and when Sida started to support training of nurses, health education, the essential drugs programme and maternal health from the mid 1980's and onwards the TA component had become an important part of the Programme and of the budget.

Major changes

After Angola's first multi-party elections in 1992, UNITA, the second biggest party, did not accept the results and a new intense phase of the war started. Huge government spending on warfare again undermined the government's commitment to the social sectors. In consequence of the political reorientation of the economy, new legislation opened for private health care and charges should be introduced in public health units. This course of events made Sida concentrate its support to the Luanda province and minimize TA.

Through the years, Sida had proposed to the Angolan party to outsource the Programme to an implementation consultant but the idea had never won approval from the Angolan side. Sida eventually decided to decrease its administrative burden and invited tenders to outsource the Programme. Thus, the Swedish company InDevelop took over in July 1995 and continued running the Programme together with the Angolan managers until 31 March 2006.

Maternal and child health in Luanda

Maternal mortality is one of the most burning human and social issues in Angola. After analysing the inhuman conditions of the big maternity hospitals in Luanda, the MoH and the provincial health authorities agreed with Sida to start building a decentralized system of obstetric services in Greater Luanda. The emphasis on reproductive health in the end of the 1980's not only led to the reorganization of the obstetric services, but also to strengthening of antenatal care and family planning, and, later, to the building up of a modern midwifery course. After the positive tendencies of the decentralization of deliveries to Health Centres, the next step was to try the same model for paediatric care. One could say that Sida and Angola succeeded in adopting a human rights approach to reproductive health – after many years of negligence women's and children's right to survival and health came to the surface.

The remaining problems to create a safe and just MCH system in overpopulated Luanda are huge and complex, and will need more time and even stronger commitment from the Angolan government and all involved structures to produce more profound results.

Analysis of the Swedish-Angolan cooperation

The “disbursement goal”

During the first agreement periods, it became evident that the MoH was unable to use funds according to agreed plans and Sida was worried about Angola's low “spending capacity”.

Through the years, it was difficult to monitor implementation of the Programme in the field. Sida was also in some instances sceptical against the Ministry's proposals and priorities. But despite scepticism and uncertainty about results, Sida did not hesitate in maintaining, or even increasing, the budgets without having any in-depth analysis together with the Angolan party.

A huge part of the support went to importation of equipment and vehicles and the highly technical projects were prioritized, as opposed to low-budget support like training and competence development, management support, etc.

Sida's "disbursement goal" created more problems than it solved, since its focus was on the money and not on implementation capacity and quality on the Angolan side. In that way, the cooperation in the health sector got off to a bad start.

Efficiency and effectiveness in war times

One of the questions behind this study is whether or not Swedish development cooperation has contributed to improved health in Angola. During the twenty seven years (1979–2006) of support to the health sector, Sida has disbursed MSEK 667, although the *budget total* was considerably higher. It is, however, not possible to evaluate the efficiency of the support and calculate the output, e.g. in terms of immunized children or graduated nurses in Luanda. Immunization statistics are not fully reliable, and, in the case of the training programme, there is no information of the number of graduates who have remained in the nursing profession.

Some important factors that have influenced the results – or lack of results – of the cooperation are centralization and bureaucracy, lack of management capacity and experience, lack of health workers and low professional level, corruption in the system and lack of discipline. But the main factor to obstruct development efforts in Angola is the war. It has consequently never been possible to implement the health programmes with full efficiency and effectiveness. Nevertheless, this review shows that some measures could have been taken by both sides to improve performance and use the available resources in a more rational way.

Results in spite of all

The examples above – immunization and nurse training – also illustrate the problem of analysing whether objectives have been achieved or not, programme by programme. We know that Sida's initially defined objectives to help building a nationwide PHC system were not achieved. But some important components of such a system have developed in an efficient way, thanks to strategic and comprehensive support from Sida and other agencies or NGOs, and, above all through well-functioning management and dedicated

work from the Angolan staff. This is the case of the Essential Drugs programme and the comprehensive MCH programme in Luanda and the specialized midwifery course, where the tendencies are positive.

When looking back at the programmes that were phased out by Sida in the 1990's, they are still surviving and performing with more or less energy. It is, though, practically impossible to isolate the effects of the Swedish support, ten or more years after it was phased out.

Is improved health possible in war and absolute poverty?

Health care in colonial times was certainly not for all, and what was taken over by the new government after Independence was, by no means, a well functioning system. But during the protracted war, the health sector rapidly eroded from an already low pre-Independence level to a situation with the infrastructure in shambles and lack of staff, equipment and drugs.

Health depends on a broad spectrum of social, economic and cultural factors, which have made Angola's health indicators some of the worst in the world. This means that Angola's catastrophic health situation cannot be seen as an isolated problem, but has to be analysed together with the extreme poverty, the overpopulation of Luanda and other urban centres, the health-impairing environment, the lack of clean water and the low educational level among the population. Peace and stability are the most important pre-requisites for people to be able to cater for themselves and their families, at community and individual level.

Lessons learned

Lack of realism

There is a lot that points towards a lack of necessary information when Sida started planning for support to the Angolan Health sector. Consequently, Sida was unable to make a realistic appraisal of the possibilities assist in building up a national PHC system meant to reach the main target group, the rural poor. Even the Angolan government lacked information about the situation outside Luanda, and seems to have had rather vague ideas about how to organize health services. The civil war was a reality, yet it took a long time before Sida realized – or wanted to accept – that it was not possible to reach out to all the provinces with the centrally managed programmes, such as Endemic Diseases and Immunization.

Social sectors undermined

Sida's support has not made any significant contribution to the development of a PHC *system* along the guidelines formulated in Alma Ata (1978). The

lion's share of Angola's resources (through the official government budget) has been spent on warfare and the social sectors have been severely undermined. In its dialogue with the Angolan party, the Swedish Embassy has now and then underlined the government's responsibility and the need to increase allocations to the social sectors, but such discussions have been without effect.

Lack of resources for PHC and vertical programmes

Another reason for the limited success is that Angola, at the time of Independence, was lacking all kinds of resources needed for establishing a PHC system worth the name. There was virtually no health staff left in the country, the colonial health system was in shambles, and the new government had not even any exact information of existing infrastructure, or of health staff remaining in the country. Moreover, the colonial system had a strong hospital bias and was thus not oriented towards prevention and PHC.

When Sida launched its comprehensive health support most of the components could be objectively interpreted as parts of a PHC system, such as "basic health care", immunization, combat of endemic diseases, and essential drugs. But in spite of the PHC character of the programme, these components were not coordinated horizontally to help building a functional PHC structure.

Several of the programmes supported by Sida were, from the beginning, organized as vertical programmes, which is not an ideal model when creating a PHC system. The already existing centrally managed programmes for combating the endemic diseases were maintained, and the immunization activities started through UNICEF's vertical EPI model. Some of the Angolan professionals were aware of the negative effects. Programmes "arrived at the Health Centres" in a vertical way, and coordination was difficult for health workers in the field without management skills. Even today, the "classical" vertical pattern persists and creates problems. At Health Centres and Posts health workers are divided up between the programmes and material, vehicles and other resources cannot be used in the most rational way.

No analysis of management capacity

The initially optimistic and solidarity based approach made Sida overlook the complexities of the health sector. Sida did not understand the overall weakness of the Angolan health institutions and of the government structures. There are no traces of analysis of the institutional and management capacity on the Angolan side to implement the rather advanced programmes. There was a need not only for doctors and nurses, but for laboratories with trained staff and health workers able to disseminate health messages adapted to the educational and cultural level in each community. These human resources did not exist in the beginning, and, equally, there were no experienced managers in the MoH organization. Angolan MoH staff were, them-

selves, conscious of their shortcomings but more hands-on instructions and training do not seem to have been introduced before the mid-1990's, when the implementation consultant InDevelop started coordinating the support programme in Luanda.

Why not training and competence development?

The Swedish support should have needed strong components of training and competence development already from the beginning to promote the development of the health sector and its institutions, with an approach well adapted to the realities in Angola at the time.

Institution building was evidently not the strong point of the Swedish support, but it is not clear whether this was due to Swedish negligence or Angolan lack of interest (or resistance to interference in a “political” area). After concentrating activities to support MCH in Luanda, it is, however, possible to discern some efforts to strengthen systems and management, although this area would have needed more time to develop and become sustainable.

The colonial legacy

Angola achieved its Independence after over twenty years of armed struggle against Portugal. The colonial power itself was one of the most underdeveloped nations in Europe, with a primitive economy and under a fascist dictatorship. Angola's Independence must be seen against a background where the building of a new nation really had to start from scratch. Health and education institutions for the African population were at a rudimentary level and there was only a very narrow élite of well-educated Angolans in the country on the eve of Independence.

Angolan public administration strictly followed the conservative and hierarchical Portuguese model. This legacy has had a very bad effect on the development of the country and central planning and detailed political control has added to the efficiency problems at all levels of state administration.

No common ground for development

The violent antagonism between the movements that pretended to liberate Angola, naturally had destructive effects long before the civil war. It was never possible to create a common ground for a national development strategy, not before and even less after Independence.

The new government had to meet the expectations of the people, and optimistically started launching activities along the guidelines of the ruling party MPLA. And when the first donors arrived in Luanda, such as Sida and the UN agencies, they accepted proposals from the Angolan government, or, to be precise, the MoH, for supporting the health sector without any deeper analysis.

Complex environment

The lack of insight into Angolan social and cultural realities is one of the reasons for the uneven tie-up between the huge input of material and human resources into the Health Programme and the relatively meagre output in the form of more and better health services. Eventually, someone understood something about the survival strategies among health workers – working, yes, but not at the official workplace – and a system of incentives was established so at least midwives started to work and improve. This is only one example of the environment in which the Health Programme was implemented. A more careful approach – and less focus on disbursement – would have created an understanding of the context where Swedish professional know-how and bureaucratic practices were supposed to fit in.

Through the years, Sida has mainly collaborated with government structures at central level. Planning on the Angolan side has been top-down, and Sida has not questioned the bases for such a planning or shown interest in participatory planning methods. Sida never tried to adopt a new approach to the problems encountered by evaluators and paid little attention to lessons learned by TA personnel working on the Angolan side.

Few socio-cultural studies and no systematic learning

Very little was done to learn more about women's own ideas about childbirth and about reproductive health in a broader sense, e.g. through socio-cultural studies by health personnel, sociologists or anthropologists. There was, thus, no systematic learning process based on studies or community work around reproductive health or other medical fields. Why do the women not use the services put at their disposal? Why do they take unnecessary risks at childbirth? What are actually their preferences when giving birth? Sida never followed up the isolated initiatives to find answers to such questions or to know more about *gasosas* and other unethical practices affecting patients and, in the long run, the results of investments made in the sector.

Community involvement

There has been too little community involvement in the Maternal and Child Health programme in Luanda. To work directly with the communities is a challenge, but definitely needed to create community trust in the health services provided. *All women*, and when possible men, have the right to get basic information about family planning, pregnancy, childbirth and child care (including hygiene, nutrition and other key aspects).

Better institutional capacity

When observing the institutional capacity today one can see a positive development at many levels. The poor Health Centres function relatively well, and, in spite of the existence of gasosas, staff perform well under the prevailing circumstances (lack of equipment and drugs, power failures, lack of information from the provincial level, etc.). Some of the programmes initially supported by Sida have maintained their activity through the years, and seem to have gained impetus after the establishment of peace.

Although the infrastructure in the health sector is still weak, some of the institutions involved in the Angolan-Swedish cooperation have been strengthened and their management capacity has slowly developed for the better.

Sida's policy: To work within the institutions

Sida's policy to work with and within the Angolan institutions is a positive experience, especially appreciated by the Angolan MoH staff. Sida avoided "taking over" persons in leading positions, like some other agencies or NGOs have done. The Swedish model was to try to strengthen and consolidate the Angolan structures through coordinators and advisers based in the MoH, improved working environment and technical input, training, etc.

People are sustainable

One of the interesting observations during this study is of people who have been involved in this long standing cooperation. While cars eventually come to a standstill after a few years, people are more robust and durable. All the over forty people interviewed for this study are still working as doctors, directors or teachers and none of them has abandoned the health sector. Many of them appreciate the professional exchange with Swedish colleagues, and some tell about their hard work with planning and budgeting to live up to Sida's strict rules! They have gone through their own development process – quite a few of them with support from Sida – and they are today a valuable asset for the Angolan health sector.

The future

Since the war and its social and economic consequences have obstructed most attempts to systems and institution building, the national health system still remains without the necessary financial resources. Today, Angola needs to establish a broadly supported, comprehensive, and socially just health policy and start (re)building health institutions more or less from scratch and with a strong community involvement. This has to be done through a national effort and with national resources, since peace and the country's macroeconomic indicators indicate enough evidence that Angola will be able to stand on its own feet if there is a political will to do so.

Introduction

The study

The Swedish support started already before Angola had obtained its Independence – first through a solidarity campaign and later via the Swedish Embassy in Lusaka, Zambia. The Swedish Embassy in Luanda opened in October 1976, as one of the first of a Western country. Since then the cooperation between the two governments has lasted for thirty years.

One of the main areas of Swedish support was the health sector. This Programme¹ started soon after Angola's Independence and was the last Sida Programme to be phased out in March 2006.

This study is trying to document and tell the story of this long period of development cooperation, which has involved many people and many institutions in both countries in a multifaceted experience of advances as well as setbacks. The Terms of Reference of the study can be found in *Appendix 1* to this report.

In the study, which does not entirely follow the usual model for Sida evaluations, we try to give an account of the Swedish-Angolan cooperation by combining the Swedish and the Angolan perspectives.

The introduction briefly tells how the Swedish public came to know about Angola and the liberation struggle in the Portuguese colonies. Political parties were debating Sweden's commercial relations with Portugal's fascist regime and a solidarity movement started to grow in support of the liberation movements in Africa.

In the first part of the report, we present a historical overview of the Health Sector support with examples of the activities and processes that received support from the 1970's until 2006. Motives and methods are reviewed and, when possible, analysed.

In the shorter second part, we look at history from another angle. We give a brief summary of the Angolan analysis of the different programmes, as it was presented in a special evaluation carried out by an Angolan team who interviewed Angolan health staff fifteen years ago (1991).

The third part of the report is an overview of the supported programmes, their development and their present situation after the Swedish support has been phased out – a long time ago or recently.

¹ The term *programme* is used in this report either for the Cooperation Programme, i.e. all components included in the specific Health Sector agreements between Angola and Sweden, or for the programmes implemented by the Ministry of Health at national level, such as the Malaria programme, etc.

In part four we present our conclusions as a basis for a discussion about what Sida as well as the Angolan counterpart institutions can learn from this long-standing cooperation under difficult circumstances.

Here we also integrate a tentative analysis of whether the Swedish support has contributed to improved health in Angola or not, having in mind that Angola has been at war practically since its Independence in 1975, and that Development Support Programmes can only have marginal effects under such circumstances. It is, though, important to try and analyse the degree of effectiveness and efficiency of the Swedish-Angolan cooperation taking into account its very particular characteristics.

Method and material

The first part of the study is mainly based on earlier evaluations. In 1991, Lillemor Andersson-Brolin and Anna-Karin Karlsson evaluated all the components of the Sida supported Programme from 1979 to 1991. During the same period, an Angolan team made a special evaluation from the Angolan perspective, which is also used as an important source. Later, Lillemor Andersson-Brolin and Hans Wessel evaluated the support to maternal health in the Luanda province in 1999 and, finally, the maternal and child health programme was evaluated by Pia Karlsson, Kenneth Challis and Staffan Salmonsson in 2003.

In April 2006, Kajsa Pehrsson and Kenneth Challis initiated an evaluation of the phasing-out of the Maternal Health programme in Luanda province and during a short stay in Luanda health staff, managers and directors at *Delegação Provincial de Saúde de Luanda – DPSL* (Provincial Health Delegation of Luanda) were interviewed. We visited some suburban Health Centres with maternity wards (*salas de parto*) and District and Central Hospitals to gather data and impressions that have been used as an input also for this study, since they reflect the present situation and the quality of the Maternal Health programme.

For this particular study, Kajsa Pehrsson and Staffan Salmonsson visited Luanda during two weeks in June/July in order to interview as many persons as possible among those who have been involved in the Angolan-Swedish cooperation through the years. We succeeded in meeting with no less than forty persons with longer or shorter experience of the cooperation, many of whom had worked together with Swedish advisers, doctors and nurse tutors. We used semi-structured and sometimes quite open-ended methods for the interviews, which often included discussions on policies as well as more technical issues. Persons interviewed are listed in *Appendix 2*.

In Sweden fourteen people were interviewed in person or by telephone, since they are spread out all over the country. Besides the interviews, we got access to 20 end-of-contract reports by Sida employed staff from the period 1988–

1993, and equally a number of reports written by staff working in Angola from 1995 to 2006 with InDevelop contracts.

Although the interview work has been quite interesting and rewarding in many aspects, it must be said that it was not easy to collect specific information from this large group of interviewed people. For many of the Angolans, the Sida experience goes a long way back in time and their memories are not always accurate since they have moved between different posts and programmes in the Health Sector. The same goes for the Swedes, although the Angolan experience as such remains as a difficult and/or interesting episode in their lives.

In addition to the interview material and field staff reports, we have used a big collection of documents from the Sida Archives made up of memoranda, agreements, agreed minutes from annual and quarterly meetings, consultancy and monitoring reports, etc., etc. This documentation covers mainly the period from the mid 1980's up to 2006. (The period 1979–91 was documented in the evaluation made in 1991.) We must, however, underline that the documentation is not absolutely complete, but all the same it provides both details and an overview of the Angolan-Swedish cooperation during almost thirty years. A condensed bibliography is found in *Appendix 4*.

Regarding the statistics presented in the report – in tables and in the text – we feel a certain need to emphasize that statistics in Angola are usually not very reliable. When possible, we have tried to assess data that appear in reports and other documents, but that has not always been meaningful. We believe that, while depicting the realities of the health sector in Angola, we have also tried to make readers comprehend the reasons why data are lacking or sometimes rather confusing.

All quotations in the report that are not originally in English have been translated from Swedish or Portuguese (and from Danish in one case) into English by Kajsa Pehrsson.

Background to the Swedish-Angolan cooperation

When Angola was put on the map

Angola, as well as the other Portuguese colonies, was practically *terra incognita* among the Swedish public until the beginning of the 1960's. However, after the attack on a prison in Luanda to free jailed MPLA leaders, and the following indiscriminate violence from the Portuguese police and bands of "vigilantes", Swedish newspapers gradually started to report about Portuguese colonialism and the initial stages of the liberation struggle in Angola, Mozambique and Guinea-Bissau, as well as about the political opposition against the fascist dictatorship in Portugal. The commercial relations between Sweden and Portugal through the European Free Trade Association (EFTA) was debated and severely criticized from different political quarters. A group of young influential liberals demanded Portugal's expulsion from EFTA in an article in the biggest morning newspaper as early as in July 1961:

We, a group of young Liberals, protest against the passivity of the Swedish government towards the dictatorship in Portugal and its colonial oppression. It is now evident to all that the 'disturbances' reported from Angola in reality constitute a war between a national freedom movement and a white minority. By accepting Portugal's membership in EFTA, Sweden gives [both] a moral and an indirect economic support to the oppression, [thereby] obstructing the freedom struggle. /.../ A clear repudiation and isolation of the repugnant Salazar regime would decisively assist the freedom movement in Angola and demonstrate that the ideals of Portugal are not those of the Western world .

(DN, 1 July 1961; quoted in Sellström, 1999, p. 371)

Some of the leading journalists and political commentators made pioneering contributions by informing the general public about the Human Rights and the onset of the liberation struggle in Angola. These articles were widely quoted in international newspapers and magazines, since at the time very little was written about Angola and censorship in Portugal put the lid on what was going on in the colonies. The Swedish section of Amnesty International followed actively the fate of political prisoners in Portugal and in the colonies. In 1967, a Stockholm theatre performed the play "The Song about

the Hideous Mask”, a satire about the dictator Salazar and about how Portugal’s colonial system was backed up by the Western countries, written by the famous German-Swedish playwright Peter Weiss.

Initially, both FNLA (*Frente Nacional de Libertação de Angola*) and MPLA (*Movimento Popular de Libertação de Angola*) appeared in the debate and leading representatives were invited to Sweden. When UNITA (*União Nacional para a Independência Total de Angola*) entered the scene, contacts were at once established.

One can roughly outline the sympathies for the nationalist movements along Swedish party lines. Leading Liberals were defending FNLA as the true representative of the Angolan people, while students and intellectuals of Social Democratic (Labour) tendency in the course of time concluded that MPLA was the right and serious alternative. UNITA had very convinced supporters among Swedish Maoists as well as among conservative Moderate party politicians and analysts. But also high-level Social Democrats developed close contacts with UNITA, through some of its young leaders who held important positions in the Western-oriented international student organization together with leading Swedish Social Democratic (Labour) student politicians. Yet, these contacts were discontinued after UNITA had returned to Angola in 1968. In 1969 the Swedish solidarity movement was mobilising popular support for MPLA, and started openly to question any support to UNITA, which was no longer seen as a genuine liberation movement. An important influence on the Social Democratic party’s standpoint on the three movements in Angola was probably the friendly contacts between the late Prime Minister Olof Palme and the leaders of ANC, FRELIMO and PAIGC that were in alliance with the MPLA. (*Sellström, 1999, p. 371–419*)

A political support – the solidarity movement and the government

The journalist Anders Ehnmark initiated the first concrete support to the liberation movements in Angola. Early on he had established contacts with the exiled leaders of the liberation movements of the Portuguese colonies and visited Lower Congo in 1961. The newspaper Expressen published a series of articles under the headline “Africa from within” written by prominent African intellectuals invited by Ehnmark, such as Mário de Andrade and others. The umbrella organization CONCP (*Conferência das Organizações Nacionalistas das Colónias Portuguesas*) approached Expressen with an appeal for funds, and the biggest newspaper in the country started the “Angola help” which raised funds in support for Angolan refugees in Lower Congo from July to September 1961. The response was extraordinary, theatre groups and artists joined the campaign and the total value collected in cash (and in kind) was 251,000 SEK. The money was used for purchase of antibiotics, which were distributed to MPLA’s medical services in Congo. (*Sellström, 1999, p. 383–390*)

During the 1960's the Africa Groups of Sweden, which existed in the university cities and in some smaller towns, were in the forefront in disseminating information about the colonial wars in Africa. In their monthly review, they were closely following the political and military developments in Angola, Mozambique and Guinea-Bissau presenting in-depth analyses of the situation in each of the countries. Together with other groups of students and scholars, the Africa Groups were instrumental in rousing public opinion in favour of the struggle against the colonial power.

In 1970, when the Liberals were defending the FNLA, and the Social Democratic party had not yet clarified its position towards the MPLA, the Angola-MPLA Group in Stockholm made a thorough analysis of the political character and objectives of the three movements existing in Angola. The issue was brought up for debate also in the Africa Groups and, in an article in the *Södra Afrika* bulletinen (Southern Africa bulletin), local Africa Groups in four cities concluded that MPLA was the only movement that deserved support. Through their active advocacy pro MPLA during the following years, the Africa Groups contributed to the fact that Swedish government assistance was never given to FNLA or UNITA.

In 1971, the Swedish government released the first official grant to MPLA, amounting to 500,000 SEK. 90% of the amount was utilized, which led the government, through Sida, to increase the amount to 2 MSEK in 1972/1973. But strangely enough, these funds were hardly used at all, without anybody understanding the reason. The assistance was of a purely humanitarian character, and aimed at supporting the large number of Angolan refugees living in the neighbouring countries under difficult conditions. But the former head of Sida's procurement division described the cooperation with MPLA as his "greatest disappointment". He had the impression that the political decision by the Swedish government to provide support to MPLA was considered more important than the material side of the assistance. (*Sellström, 2002, p. 110*)

During the first years, the administration of the assistance was complex and tortuous; since the MPLA – often with Dr. Agostinho Neto in person – changed priorities and delivered new commodity lists now and then. But later on complications of a political character appeared because of the agreement between MPLA and FNLA in 1972 and later because of internal conflicts within the MPLA. The commodity support programme was managed by the Sida office at the Swedish Embassy in Lusaka, but also via contacts and negotiations with the MPLA representation in Dar-es-Salaam, depending on the circumstances.

After the suspension of Daniel Chipenda in 1973 and the following crisis in the MPLA, the cooperation came to a standstill. The Swedish Embassy and Sida in Lusaka were influenced by the Zambian government's critical view of the MPLA, and the Swedish disbursements were withheld after local deci-

sions at the Embassy. MPLA feared that the assistance had been cancelled, which, however, was not the case, since support to a school in Congo through UNESCO continued, as well as deliveries of procured commodities. Disbursements were actually higher than the year before. And eventually, Sida's internally divided opinions were clarified.

In April 1974, just a few days before the military coup in Portugal, Agostinho Neto made an unannounced visit to Sweden, and new agreements and budgets could be settled. But nobody expected things to change over night, and shortly details had to be modified, so that projects could move from Congo cross border to the North of Angola, and the contents of the commodity programme had to be partly changed to adapt to the new situation after the 25th of April 1974.

The researcher Tor Sellström makes a pertinent analysis of the Swedish assistance to MPLA before Independence in one of his books about Sweden's role in the national liberation in Southern Africa:

By far the least favoured of the seven African liberation movements supported by Sweden, the official aid relationship did, nevertheless, amount to a *de facto* recognition of MPLA as Angola's legitimate 'government-in-waiting'. This is also how it was understood by the leadership of MPLA, as well as by the competing FNLA and UNITA movements. Despite mutual frustrations regarding the implementation of the humanitarian support and against the position taken by other actors close to Sweden – notably the Zambian government – the Social Democratic government never broke with MPLA or established official links with Daniel Chipenda's *Revolta do Leste*, FNLA or UNITA. The relations established through the Swedish assistance made it possible for the two parties to find common ground and establish a lasting political relationship. (Sellström, 2002, p. 131)

We're closing down the city

Everybody was busy building crates. Mountains of boards and plywood were brought in. The price of hammers and nails soared. Crates were the main topic of conversation – how to build them, what was the best thing to reinforce them with. Self-proclaimed experts, crate specialists, homegrown architects of craters, masters of crate styles, crate schools, and crate fashions appeared. Inside the Luanda of concrete and bricks a new wooden city began to rise.

...

So by night, in the thickest darkness, we transfer the contents of the stone city to the inside of the wooden city. It takes a lot of effort and sweat, lifting and struggling, shoulders sore from stowing it all, knees sore from squeezing it all in because it had to fit and, after all, the stone city was big and the wooden city is small.

...

Nowhere else in the world had I seen such a city, and I may never see anything like it again. It existed for months, and then suddenly began disappearing. Or rather, quarter after quarter, it was taken on trucks to the port. Now it was spread out at the very edge of the sea, illuminated at night by harbour lanterns and the glare of lights on anchored ships. By day, people wound through its chaotic streets, painting their names and addresses on little plates, just as anyone does anywhere in the world when he builds himself a house. You could convince yourself, therefore, that this is a normal wooden town, except that it's been closed up by its residents who, for unknown reasons, have had to leave it in haste.

But afterwards, when things had already turned very bad in the stone city and we, a handful of inhabitants, were waiting like desperadoes for the day of its destruction, the wooden city sailed away on the ocean. It was carried off by a great flotilla with which, after several hours, it disappeared below the horizon. This happened suddenly, as if a pirate fleet had sailed into the port, seized a priceless treasure, and escaped to sea with it.

...

I don't know if there had ever been an instance of a whole city sailing across the ocean, but that is exactly what happened. The city sailed out into the world, in search of its inhabitants.

*In: Kapuściński, R. (2001) **Another day of life**. Translated by William R. Brand and Katarzyna Mroczkowska-Brand.*

Did Angola get peace?

After the peaceful “Carnation revolution” on 25 April 1974, Portugal’s empire was doomed to collapse. The colonial war was the main reason why dissident officers staged a military coup d’état, which led to the Independence of the African colonies. In the case of Angola, Lisbon preferred to relinquish power to a unified government and took an active role in the reconciliation between the three liberation movements. Equally, the OAU was putting the leaders of the MPLA, FNLA and UNITA under pressure to make them form a united front. Thus in early 1975 these three movements recognized each other, with equal rights and responsibilities, and agreed on a transition period to prepare the ground for Independence.

On 10 January, the liberation movements and the Portuguese government set the time for Angolan Independence to 11 November 1975. Under the Alvor Agreement, a transitional government was formed, including the MPLA, FNLA and UNITA.

However, the parties represented in the transitional government failed to settle their profound ideological differences and the frail transitional government was dissolved and heavy fighting broke out in July. UNITA formed an alliance with the FNLA and a full-scale civil war broke out after UNITA's declaration of war on the MPLA on 1 August 1975. MPLA came to occupy all the seats in the Angolan government after the coalition breakdown.

The Angolan post-Independence war was a proxy Cold War conflict up to 1992. The two sides were financially and militarily supported in accordance with their ideologies. Consequently, the Soviet Union and Cuba stood behind the socialist MPLA, while UNITA, ethnically based and strongly anti-communist (although initially supported by China), received its main support from apartheid South Africa and the US.

Since then the Angolan people have been living in the midst of a civil war until 2002. A large proportion of the national territory has been under UNITA's control, and during more than 25 years the war has been the main concern of the government. The fighting has caused devastation of towns and villages, agricultural land has been abandoned or cannot be farmed because of landmines and infrastructure all over the country today lies in shambles. The war has brought untold suffering to millions of Angolans in form of food insecurity and starvation, diseases among children and adults, lack of protection, violence and crime. Several generations have been affected, and the effects of their sufferings and traumas will remain and also affect coming generations.

One of the most severe consequences of the war, at societal level, is the huge number of internally displaced persons. Already at Independence, lots of people migrated from the rural areas towards the bigger cities, chiefly Luanda. As warfare intensified, more and more people were forced to leave their home districts² in search of security and means of survival. Between 1998 and 2002 more than three million war-afflicted people fled from the rural areas to the safer cities. In 2006, Luanda, a colonial capital planned for half a million people, had a population of around five million according to estimates³.

Needless to say, the health conditions among the Angolan people have been affected and all health indicators show a disheartening situation.

² Angola is administratively divided into 18 provinces (*provincias*), 163 districts (*municípios*) and 532 communes (*comunas*).

³ No complete population census has been carried out since 1970. The National Institute of Statistics (*Instituto Nacional de Estatística*) has made several Multiple Indicator Cluster Surveys (MICS). They are based on a sample of districts where the security situation permitted field work during the war and have demographic estimates and other statistic information. Estimates of the population in Luanda province have been made through aerial photograph technique in recent years.

Health care in the colonial times

The health care system during colonial times was concentrated to the cities and to the regions of economic importance. It had a mainly curative trend and was predominantly under private management. The only exception was the programme for control and treatment of trypanosomiasis, which was organized by the state authorities. Trypanosomiasis was mainly prevalent in some of the regions in the North involved with coffee and other cash crop production, which made it a priority for the state to control the disease. Angola had developed a unique expertise in fighting trypanosomiasis, and in 1973 the disease was practically eradicated in the whole country.

The state was also responsible for the training of *Agentes Sanitários de Assistência Rural* (Health Agents for Rural Assistance), a category of health workers at village level who also engaged in agricultural extension. Approximately 2,000 agents were trained during the 1960's and 70's.

The health sector was mainly in private hands, and the qualified medical care was concentrated to Luanda and the other bigger cities. The missions had doctors and trained nurses – Angolan or expatriate – and were important caregivers all over the country. There are, however, no available data regarding the private medical services or the missions.

Statistics from pre-Independence are difficult to interpret, since it is believed that the colonial authorities were cooking figures to make statistics look better internationally. In 1973, infant mortality was 59.8 per 1,000 live births. Of the total number of deaths, 30% were caused by acute diarrheic diseases, 4% by measles, and 0.5% by malaria. No data are available for tetanus.

The nursing courses had a lower quality than comparable courses in Portugal, and only in the 1970's the system underwent a reform to rectify this. In the late 1960's the Faculty of Medicine opened in Luanda, but the majority of the students came from Portugal. Very few African students had access to professional and higher education, which left Angola with very few trained health staff after Independence. Most Portuguese nurses and doctors left the country, as well as administrative and technical staff in the sector.

One of the doctors interviewed in 2006 gives a picture of the situation at the onset of Independence:

– In 1975 there was only one Angolan doctor in the South of the country and that was me. I was young, and didn't have much experience. I was supposed to bear up the whole health structure, which was sustained by *enfermeiros* [male nurses] and X-ray and laboratory technicians. I got to know practically all the districts in Cunene, Namibe, Huíla and Kuando-Kubango.

Source: Björck, M. (undated) **Background report for Sida's support to the Health Sector in Angola** (in Swedish) and interview with Dr. Raúl Feio.

Part 1: The start

The prelude – first request about health support

Bilateral cooperation between Angola and Sweden was established in a general agreement already in October 1976. This happened just a few weeks after the Swedish Social Democratic party for the first time in many decades had lost the parliamentary elections, and the new government was a liberal/conservative three-party coalition. The new government found no reason to go back on cooperation programmes already agreed on by the former government, although Angola's and MPLA's Marxist rhetoric certainly was in glaring contrast to the new, liberal political line in Sweden. But there was a political consensus around decolonization, and the liberation of the former Portuguese colonies was received with satisfaction by all democratic political tendencies. The very first Sida officer in Luanda, Ms. Carin Norberg, currently states that the new government looked upon the liberated Angola as "*the Land of the Future*", and that there was a sincere interest in helping Angola to get on to its feet after Independence.

In April 1977 Angola contacted Sida for support to import health care equipment. Since the Swedish government was well aware of the emergency situation in Angola, two delegations were sent to Luanda during summer 1977. The first was a high level delegation headed by Mr. Ola Ullsten, Minister of International Cooperation, and also included the Director General of Sida, Mr. Ernst Michanek. The second, more technical, delegation was composed by a consultant and a programme officer from Sida's Health Division.

Both delegations were favourably impressed and concluded that the needs were tremendous and that the ongoing plans were well-formulated, even though a bit unrealistic. Would it at all be possible to reach out and improve the health services for the rural poor? And what could be the effects of the recently attempted coup d'état? But in spite of these doubts, both delegations found that the country was in crying need for support to practically all fields in the health sector. Such a support was also considered to be of strategic importance in defending Angola towards the South African aggression. These conclusions were the main motives when the delegations decided to suggest the health sector as a concentration area in the Development Cooperation Programme between Sweden and Angola. This decision became the start of a cooperation that would last for almost 30 years.

The MPLA congress – planning for health after Independence

The first Angolan health policy was adopted during the first Congress of MPLA in December 1977, two years after Independence. The Congress decided that Angola should have a health care system where Health Posts and Health Centres were given a crucial role to cater for Primary Health Care (PHC) all over the country⁴. Health care should be free of charge and preventive health care a priority based on immunization, health education and environmental hygiene. Health care at Centres and Hospitals needed to be improved through more qualified and better-trained health workers. These institutions all came under the MoH.

The public health system had to be totally reorganized. At village level *assistentes / agentes sanitários* (village health workers) and *parteiras tradicionais* (Traditional Birth Attendants, TBAs) should assist the rural population. A *Posto de Saúde* (Health Post) should serve 10–15,000 people, while a better equipped *Centro de Saúde* (Health Centre) should serve 20–50,000 people. Next level in the system was the *Hospital Provincial* (Province Hospital) with a service area of 150–200,000 people or more.

At the time, the Angolan government had no accurate and reliable information about the state and number of health care institutions in the country (Posts, Centres and Hospitals), let alone about the number and categories of staff. The Congress therefore stated that the plans for the health sector had to be flexible. As a first goal, the Congress decided that 100 *Centros de Saúde* and 400 *Postos* should be built/rebuilt until year 1980.

What to support within the health sector?

At this time Angola was supported by the United Nations (UN) through UNICEF, WHO, and UNHCR, by several Eastern European states as well as by Cuba. The Swedish delegation thought that cooperation should be mainly channelled through the UN, but the Angolan party strongly opted for a bilateral support. Moreover, the Angolan delegation asked for support in the form of technical assistance (TA), a request that the Swedish delegation rejected. The Swedish representatives stated that it would not be possible to recruit Swedish health staff for Angola, since there were no Swedish experts with sufficient knowledge of Portuguese. Another obstacle was the precarious housing situation in Luanda for expatriates, since the city was overcrowded as a consequence of the war.

⁴ The model had much in common with that in other African countries.

The first agreement

While preparing for the first cooperation agreement, the Sida Development Cooperation Office maintained formal as well as informal contacts for gathering information and discussing Angola's proposals. Ms. Carin Norberg especially remembers the late Dr. David Bernardino as one of the most important and convincing counterparts when it came to making the Sida officers understand Angola's crying need for support to the health sector.

In May 1978, Sida sent a group of experts to Angola to identify areas of cooperation. The expert team concluded that it was impossible to design a detailed support Programme. There were few reliable, quantitative data at hand, it was not clear whether the support could be channelled through UN agencies, and finally, the war could disrupt the plans.

With this reservation the delegation suggested the following seven areas:

- Immunization
- Water
- Malaria
- Nutrition
- Transports
- Domestic production of essential drugs, and
- Health Centres and Health Posts.

PHC activities for poor people in rural areas were the cornerstone of Sida's Health Policy⁵, formally adopted in 1982. These seven strategic areas were in tune with the policy and Sida embarked on the undertaking to improve PHC in the rural areas all over Angola.

In this *first agreement*,⁶ 41,3 million Swedish Crowns MSEK were allocated for a period of three years (1979–1982). 20 MSEK would be used specifically for PHC and water programmes in the countryside, an intention that reflected Sida's policy to support the health sector. Sida, however, pointed out that the selected areas were to be seen as temporary, and that the direction of the support could change in course of time. Consequently, Sida staff and health consultants paid several visits to Angola during the first years of the health sector support.

At Sida doubts aroused very early on whether this programme would, in reality, benefit those in most need of health services or even reach out to the provinces as intended. One of the programme officers, who participated in negotiations between Sida and the Ministry of Health (MoH) in Luanda, recalls that the Angolan officials fully agreed with Sida's Health Policy and its

⁵ Sida's Health Policy was formally adopted in 1982 but was used as a guideline some years earlier.

⁶ Specific agreement for the health sector.

focus on poor people's access to PHC. Yet, when it boiled down to brass tacks, the first priority of the Angolan delegation was a modern X-ray unit for one of the big hospitals in Luanda. After a time the Sida jargon going the rounds talked about "health support to Luanda" since it was suspected that most of the resources stayed in the capital. Although some of those involved at Sida tried to bring these crucial issues up for discussion with the intention to better adapt the health support to the complex Angolan reality, there was no response from those at leading positions at Sida.

Expectations unfulfilled

Gap between budget and disbursement

The various Programme components developed differently. While the water, nutrition⁷, and immunization⁸ parts of the Programme functioned well Sida found that the programme to fight malaria⁹ did not develop as planned. Strangely enough, and without any deeper analysis, Sida then doubled the amount to the malaria programme, which was extended to include trypanosomiasis (sleeping sickness), tuberculosis (TB) and leprosy. Although it was never overtly expressed, there appeared to be a strong motive for disposal of the agreed annual budget, which was very generous considering the Angolan “absorption capacity” at the time. The programmes for control and treatment of trypanosomiasis and leprosy turned out to be able to absorb quite a lot of financial resources, but nevertheless only about half of the budgeted amount could be disbursed.

Table 1, 1st agreement, 1979/80–1981/82

Programme	Budget, MSEK	Disbursements
Development of Primary Health Care (bilateral)	10.0	0.6
Extended Programme of Immunization (UNICEF)	5.0	3.2
Malaria Programme (WHO)	6.0	7.0
Water (UNICEF)	10.0	7.2
Nutrition (UNICEF)	9.0	2.1
Transports (bilateral)	1.3	-
Total	41.3	20.1

This low level of disbursement was a serious concern for Sida, since the development aid budget had always been a topic for polemic political debate in the Swedish Parliament and the media. Therefore, it was important to spend allocated funds although it soon became evident that Angola, a nation that had just become independent with a lack of experienced government and other staff, was unable to implement activities according to the agreed plans.

⁷ Water and nutrition programmes implemented by UNICEF.

⁸ The immunization component was part of the Extended Programme of Immunization, EPI, implemented by UNICEF.

⁹ At the time part of WHO's malaria programme.

During the Annual Consultations, the Angolans and Sida raised very different questions. The Angolans repeated their wishes about technical assistance and to have the UN support replaced by an extended bilateral cooperation, including e.g. psychiatry. Sida wanted to give priority to maternal and child health, but was informed that this area already had more resources than it could absorb. Thus, the situation could rather be described as two monologues instead of a dialogue between partners. According to Swedish participants in the meetings the reason was to be found in the MoH, and a Swedish consultant claimed that *“the appointments were based on political rather than professional criteria”*. (Brolin & Karlsson, Sida, 1991)

Attempts to bridge the gap

In January 1983 Sida carried out its annual sector review as a follow-up of ongoing activities and to prepare for a new three years' agreement. In the instruction from Sida's Director General the review team was requested to see to improving the coordination between the supported programmes in the field, as the lack of coordination was considered a serious problem. Furthermore, the team was instructed to reduce the number of components of the Programme, and to particularly analyse the malaria programme in this connection.

During the review it soon turned out that there was a divergence between Angolan expectations and Sida's views on the cooperation. While the Sida representatives made efforts to keep down the number of components and, again, insisted on channelling the support via UN agencies, the Angolan MoH expressed wishes about support to a National Institute of Health and to PHC in six pilot zones. In retrospect, it appears like both sides were sticking to their own illusions about what would be possible to achieve under the prevailing difficult conditions in Angola.

Consequently, the negotiations ended up with several compromises from both parties, which in reality meant reformulations of the Cooperation Programme that were merely cosmetic. So did the Sida team, for example, solve the dilemma of reducing the number of components by re-defining several programmes as PHC activities, thus partly satisfying the Angolan party and, at the same time, keeping within the framework of Sida's Health Policy where PHC was a priority.

The parties agreed on a budget of 45 MSEK for the next agreement period 1982/83–1984/85¹⁰. The programme for control and treatment of endemic diseases continued to be the largest budget post with 16.5 MSEK.

¹⁰ The Swedish fiscal year ran from 1 July to 30 June. From 1997 the fiscal year coincides with the calendar year.

Better spending of aid money

At the end of the period of this *second agreement*, 80% of the budget had been spent, i.e. 36.5 MSEK, which Sida considered as progress from the disbursement point of view. However, the original objective, formulated in 1978, to support PHC and to benefit the rural population was difficult to realize, and only one third of that budget item was used (3.7 out of 11.5 MSEK). Sida therefore considered it necessary to deviate from the policy to support PHC in rural areas. The option was to direct the support towards the central administration of the MoH, but only as a temporary measure.

From January 1983 an assistant Programme Coordinator, Dr. Martin Björck, was placed at DNSP-*Direção Nacional de Saúde Pública* (National Directorate of Public Health) as the first Swedish adviser. One of his duties was to follow up the Programme continuously, and Sida thus centred its hopes on him to improve coordination of the various components so that the MoH would be able to spend the allocated resources according to the plans.

Table 2, 2nd agreement, 1982/83–1984/85

Programme	Budget, MSEK	Disbursements
Primary Health Care	11.5	3.6
Extended Programme of Immunization	4.5	7.5
Endemic Diseases (Malaria, TB/Leprosy, Trypanosomiasis)	16.5	12.5
Water	6.0	6.5
Transports	4.5	5.2
Nutrition	2.0	0.5
Other components (not included in agreement)	4.1	0.7
Total	45.0	36.5

Conflicting views and interests

During 1985, Sida and Angola again prepared a *third agreement* regarding support to the health sector. The Angolan government notified that they wanted to change the cooperation to better adapt it to the trying situation in the country. The peace process with South Africa had been interrupted, and several incidences of sabotage were reported. The health situation had worsened while the Angolan health budget had decreased considerable (from 10% of the general state budget in 1980 to 6% in 1985). PHC services and outreach in the country had become even further limited compared to what it was immediately after Independence. Angola wanted an increased budget and suggested 26 MSEK for 1986, which comprised four new components and an extension of Swedish technical assistance from two posts to some nine to ten for the coming three years.

Table 3, 3rd agreement, 1986–1988

Programme	Budget, MSEK	Disbursements
Primary Health Care Planning (incl. planning of Human Resources) 3.9		
Extended Programme of Immunization	10.5	
Health Education	4.2	
Essential Drugs	12.5	
Endemic Diseases	34.5	
Transports	6.6	
Training of Nurses (<i>Instituto Médio</i>)	10.0	
Total	73.2	72.0 (appr.)¹¹

The Sida delegation that visited Angola for the negotiations again carried an instruction to concentrate the Programme and reduce the number of components. It was therefore with some hesitation and a certain agonising that the delegation agreed upon a budget and allocated 73 MSEK for the coming three-year period. The issue of concentration was again approached by Sida through redefining concepts and categories in the Programme. This time, the Sida delegation motivated the large number of components with the argument that the comprehensive Programme could be defined as *health sector support*. Such a definition allowed Sida to start supporting areas which were not supported by other international agencies, provided they were interrelated. Well-grounded arguments were formulated for each component to be supported, and when the new agreement (1986–1988) was ratified in December 1985 the support was described by Sida as carefully prepared and well-reasoned. Water and sanitation support had been eliminated, but PHC support remained and the Programme from now on included support to essential drugs for Health Posts and Centres in seven provinces¹², training of health staff, and health education. During the preparation of this agreement, Sida again underlined the persisting problem with the lack of coordination between the different components of the Programme. Support to the Planning Department in the MoH was, thus, added in this agreement, as a means to strengthen the capacity of the Ministry. From 1986 and practically twenty years ahead the Programme included a coordination function to support the MoH with planning and administrative tasks¹³.

The Annual Consultations during the third agreement period reflect an optimistic view, especially among the participating experts. When the Sida delegation presented its report one of the medical experts made a separate

¹¹ It is not always possible to give exact figures for disbursements with the available documentation because the Swedish fiscal year ran from 1 July to 30 June.

¹² An assortment of essential drugs was imported and distributed in kits, with assortment and quantities calculated for Centres and Posts, respectively.

¹³ During the period 1995–2006 this function was performed by the InDevelop representative.

statement, where he expressed his positive impressions of the implementation of the Health Programme. He meant that the Swedish support had developed into an integrated support to the development of PHC and that the vertical programmes were now integrated. The malaria programme, for example, had *“developed very positively and has been integrated into primary health care in a way worth following”*. This view was not always shared by Sida’s Health Division in Stockholm. In a memorandum, the Programme Officer at the Health Division instead stated that *“Sida must learn to cope with truth, as it is. It will take a long time before we can see results, since the odds are not too good”*. (Brolin & Karlsson, Sida, 1991)

Modifications of the support

Inconsistencies left without analysis

In 1988, Sida started the preparation for the *fourth agreement* (1989–1992, later prolonged to 1993) by looking back. During the preparatory phase, Sida declared that the Swedish party wanted to keep the same objective as before: Support to PHC which is reaching the people and capacity building oriented towards the PHC level. No important changes should be introduced and the supported programmes should now be consolidated.

Table 4, 4th agreement, 1989–1992

Programme	Budget, MSEK	Disbursements
Comprehensive Planning	19.5	
Extended Programme of Immunization	17.2	
Health Education	5.8	
Essential Drugs	35.5	
Endemic Diseases (also incl.HIV/AIDS)	41.5	
Training of Nurses (<i>Instituto Médio</i>)	10.0	
Maternal Health	9.7	
Studies/Evaluation	2.0	
Total	165.5	109.5 (appr.)

In a project memorandum the Health Division established the fact that plans had not been carried out as foreseen, and that there was still a considerable gap between budget and disbursements. Sida explained the gap with the “*unrealistic planning, lack of executive capacity, and the war*” without further analysis. (*Project Memo, Sida, September 1988*)

In the same memo Sida stated that the number of components of the Programme should remain constant, but almost excused itself by saying that “*this, to a certain degree, is compensated for through synergies between some of the programmes*”. Sida thus assumed that some of the programmes were co-operating, but without mentioning any examples at all. This seems to have been more of wishful thinking than a true picture of reality. During 1986 and 1987

twelve Swedish nurse tutors and advisers had been recruited¹⁴. Sida concluded that the Swedish advisers and planners had contributed to improved effectiveness and that it was necessary to continue the support to the public administration, i.e. to the MoH.

Some difficulties were, however, identified. Firstly, the technical assistance caused a quite heavy administrative burden for the Health Division at Sida headquarters, although recruitment was made by ICH, the International Child Health Unit at Uppsala University Hospital. Outsourcing the Angolan health support had earlier been discussed but strongly rejected by the Angolan party. The issue was now again brought up by Sida, and this time the arguments were stronger.

Secondary school for survival

In the 1980's there was a severe shortage of food and all kinds of consumer goods in Angola. The government had established a rationing system, which divided people up into different categories. Ordinary workers had the right to buy a selection of basic products, while people with medium level education got supplementary ration cards with access to shops with a better selection of products, and those with a university degree were even more privileged. Since salaries (for everybody) were far from enough to survive on, people were trading all kinds of goods and foodstuff.

Mrs Kerstin Bertilson is one of the Swedish *cooperantes*¹⁵ who was working in the MoH when the support to *Instituto Médio de Saúde de Luanda* started. She explains that a strong motive for students to take a medium level course was simply the rationing system – studies had become a survival strategy.

She wonders why Sida did not make more profound studies of the Angolan society and its different realities before embarking on long-term engagements with expensive Swedish staff and with very uncertain effects for PHC in the country.

The story of the ration cards was, in fact, confirmed by Dr. Lino Silili, who is the present director of what is today called *Escola Técnica Profissional de Saúde de Luanda* (Luanda Technical Vocational Health School). In the 1980's, middle aged and old people even started to study at the University just to get the supplementary ration card.

Source: Interviews with Mrs. Kerstin Bertilson, Human Resources Planner, MoH, 1987–89, and Dr. Lino Silili, former Coordinator of the Nursing Course, and present Director of ETPSL.

Secondly, it had become evident that the kind of nurse training which was taking place at *Instituto Médio de Saúde de Luanda* (Medium Level Health Institute of Luanda), and was absorbing five Swedish nurse tutors, would in reality not contribute to improve primary health services in the periphery, which

¹⁴ Five nurse tutors at the school for nursing professions (*Instituto Médio de Saúde*) in Luanda; two human resource planners in the MoH as; two medical and pharmaceutical advisers in the National Directorate for Essential Drugs (*Direcção Nacional de Medicamentos Essenciais*) working with the Essential Drugs programme; one assistant programme coordinator at the Planning Department (*Gabinete do Plano*) of MoH; one adviser at the Public Health Directorate (*Direcção Nacional de Saúde Pública*) of MoH; one health education adviser at the same Directorate.

¹⁵ The Portuguese term *cooperante* is broadly used for expatriates working for governmental or UN agencies, NGOs or consultant companies to give technical assistance.

was the long term objective of Swedish support (ibid. 1988). The school for nursing professions offered courses at medium level (*técnicos médios*) and these nurses were not interested in working at *Centros de Saúde*, i.e. PHC level, let alone at small and distant *Postos de Saúde* in rural areas. Instead they used this upper secondary course to try to get into the Faculty of Medicine or other faculties. And if they did not continue their studies, they were usually employed in hospitals or as administrators. Many of them did not even remain in the health sector.

The doubts about the support to the nursing school and the fact that the TB programme had been criticized in an evaluation, did not inspire Sida to make any thorough analysis of effects and results in relation to the constantly increasing budget. Inconsistencies between Sida's policy and the practice in the field were therefore left without further action, and Sida's position was that of consolidating the Health Programme in its present shape. It would last several years before the idea about outsourcing was realized. "Don't rock the boat" appears to have been an important Swedish principle in the cooperation during a long period.

The documents from the discussions during the negotiations of the new agreement reflect a certain irritation. Sida's criticism of the Angolan management was interpreted by the Angolans as a harder negotiation climate. This view was further reinforced when outsourcing of the implementation of the Programme this time became a key dialogue issue, in spite of Angola's very clearly declared negative standpoint on several occasions.

Maternal health added

Since data had reported an extremely high (institutional) maternal mortality rate in the country, Angola expressed interest to include also maternal health in the Programme. Sida agreed to set aside approximately 10 MSEK for maternal health. This was, in fact, the start of a multifaceted Maternal and Child Health (MCH) programme that would last for sixteen years.

The final budget for the period 1989–1992 amounted to 165 MSEK, i.e. about 40 MSEK per year. The endemic disease programmes, which now also included HIV/AIDS, still received most of the resources, or 25% of the total budget. The essential drugs programme came next with 21% of the budget, and almost 20% was allocated to the college of nursing.

Interestingly enough, women's issues¹⁶ for the first time appeared under a special headline in the agreed minutes. The ambition to support women was also reflected in a considerably larger amount of money allocated to the maternal health programme than in the originally agreed budget.

¹⁶ At this time Sida still talked about "women's issues", and only after 1990 the term "gender" was becoming more established.

The maternal health component was limited to the Luanda province. It was mainly based on a study made in 1988 by Dr. Staffan Bergström, a Swedish obstetrician with solid professional experience from Mozambique. His most important recommendation was to build up a system of small maternal wards in the periphery of Luanda, in order to decentralize deliveries and relieve the pressure on the two big public maternal hospitals in Luanda, *Lucrecia Paím* (national level) and *Augusto N'Gangula* (provincial level)¹⁷. Both hospitals were, at the time, monstrously overcrowded and their maternal mortality figures were appalling. But the first action taken under this agreement was to contract a Swedish obstetrician to work with the recently established coordination structure CAOL (*Coordenação de Atendimento Obstétrico em Luanda*/Coordination of obstetric treatment in Luanda). CAOL as such got financial support, since it was supposed to play an important role to reform and restructure the maternal health care with the objective to reduce maternal mortality and improve the services for pregnant women. This was all in line with Sida's policy to make Swedish development programmes and resources reach women to a higher degree than earlier. (*Project memo, Sida, 1988*)

Conditions formulated – but optimism remains

For the Annual Consultations in November 1989, Sida had – again – instructed its delegation not to accept any new components or changes in the technical assistance, even if the needs were considerable. The delegation should discuss ways to reach out to provinces and districts with PHC activities, and, equally, how to coordinate different PHC components, such as immunization, maternal care, endemic diseases, etc. The instruction underlined that each component should be thoroughly discussed and analysed, and that women's issues should be highlighted. The delegation was also reminded about a detail that started to appear in several countries at that time: Swedish development aid funds could not be used for financing of “regular benefits”, such as topping-up of salaries of Angolan staff. Furthermore, the delegation should make it clear that project plans must be ready in advance otherwise Sida would cancel the disbursements. In sum, Sida formulated a number of conditions for the support.

Nevertheless, as usual, the focus of the discussions during the review was more on the future than on experiences and lessons learned in the past. And as most often, the review was characterized by optimism and a belief in peace in the country in the near future, and an important part of the conversations was about the possible geographic expansion of the Programme when security so allowed. In a travel report, one of the members of the delegation refers that the Annual Consultations were carried out “*at high speed and with daily meetings that did not allow any field visits*”.

¹⁷ Luanda also has four private hospitals with operating theatre and approximately 50 clinics for gynaecology, obstetrics and antenatal care.

Striving for improved coordination

Both during 1989 and 1990 around 90% of the budgeted amounts were disbursed, and the Sida delegations could focus on how to improve the quality of the programmes instead of persistently urging the MoH to endeavour to spend the allocated funds.

When the Annual Consultations were held in November/December 1990, they differed slightly from the usual meeting ritual. A team of experts visited all the Sida supported programmes to follow up recent evaluations in order to get a more solid basis for the negotiations. The team tried to see how the different programmes were connected/ coordinated, which had been an issue in the beginning of the cooperation. The horizontal coordination had, however, been passed over since the aim of the support gradually had become complementary to other international support.

With this coordination perspective, the Swedish delegation concluded that the training programme ought to be the hub of Sida's future support. However, due to lack of time during the review this idea was not elaborated further with the Angolan party.

In January 1991 Sida's board of directors formulated a memo where it was stated that training, institution building and transfer of knowledge were to become key activities in all programmes in the future. This memo once again emphasizes the need of reducing the number of supported components.

The focus should be on

Broadened nurse training, recurrent training of health staff in the essential drugs and maternal health programmes, health education plus support to planning, including management training.

(Memo, Sida, January 1991)

Furthermore, the memo states that Swedish TA staff should be limited to areas like coordination, planning and methods development. But when the memo talks about future engagement, nothing is said about experiences from more than ten years of cooperation.

There is no explicit information about how these issues were treated in the Angolan-Swedish discussions that took place in March 1991 to prepare the plans for the period July 1991–June 1992. It is, though, reported that Sida suggested a closer cooperation with UN for the PHC and water programmes (which were no longer included in the Sida Programme). However, according to informants, Sida had already at this time decided to outsource all the health support, either to multilateral organizations or to a Swedish company. This approach was the underlying motive for the suggested direction of the support.

The health situation in the end of the 1980's

Demographic data

Demographic data are uncertain, since population censuses were only undertaken in four provinces after Independence. These data are used for demographic estimates at national level. Population growth is high (2.8%), as a result of a very high fertility rate of 6.8% children per woman. As expected, the population pyramid has a broad base, with 44.8% below 15 years and only 3% over 65.

Health indicators

Data on intrahospital mortality ratio show a great regional variation. The most serious situation is encountered in Luanda, 11.1/1,000 live births, while Cabinda has a far better situation with 1.8/1,000 live births during a defined period. Cabinda has the highest percentage of institutional deliveries in the country, 61.4%, while Luanda has 47% and 18.8% for the whole country.

In 1983, the proportion of children with a birth weight <2,500 g was 17.5% in Luanda and 20.7 in the whole country, and 13.6 respectively 24.3 in 1987. Regional variations are very big, and the provinces most affected by the war have the worst figures, e.g. Kuando Kubango with 65.6% and the Eastern region of the country with 48%.

The under-five mortality in malaria has been steadily increasing since 1983, although diarrheic diseases remain the most important cause of death for children under five.

The PHC system

According to an inventory made in 1988, only 46 of the 163 districts (28%) have a doctor. In 1981 Cuban doctors were working all over the country, and 70–80% of the districts had a doctor, but the Cuban doctors were withdrawn in 1982–83. Doctors are mainly concentrated to Luanda.

The other staff employed by MoH consists of 25,000 people, of which 38% are *técnicos*¹⁸, i.e. trained nurses of different levels. The biggest category, around 6,000 (82%), is made up of assistant nurses (*técnicos básicos*), who usually work at Health Posts, while only 15% are nurses (*técnicos médios*) who are supposed to work at Health Centres or in Hospitals.

Because of the war, 18% of all health institutions are closed or destroyed. In the Southern region 36% are closed, in the East 28% and in the North 22%, while in the Central region almost all function.

Data regarding the coverage of the PHC system show that antenatal care exists at 203 units (12% of totally 1,722), which is a considerable increase in a few years. Family planning does only exist at 23 units in the country, but in 1984 the number was 2! The permanent immunization posts have increased from 105 in 1980 to 183 in 1988 and oral rehydration treatment is administered at 139 units. Microscopic examination for TB is carried out in 59 units in the country.

Supervision is a major problem, since 201 of the totally 532 communes are out of reach for security reasons. Communes in the Northern, Eastern and Southern regions are the most isolated.

Source: Björck, M. (1989) **Summary and analysis of the report from MoH of the health situation in Angola for the meeting of the Central Committee of the MPLA May 1989** (in Swedish).

¹⁸ The Portuguese term *técnico* is used for all professionally trained staff in the public sector.

Reorientations

In the end of May, the MPLA and UNITA signed a peace agreement in Bicesse, Portugal, and for the first time in several decades the Angolan people started to believe in a real peace in the country. Preparations started for the first multi-party elections, which were held in September 1992. MPLA won the elections narrowly, but the results were immediately contested by UNITA. Under its leader Jonas Savimbi, UNITA resumed the war again, and another violent period increased the sufferings of the people and paralyzed lots of activities anew.

After breakdown of the relative peace, Sida announced that the conditions for discussions about a new agreement were not very appropriate, as the MoH was weak due to the fact that many key persons had left their posts.

Another important question mark was the new law for the National Health System (*Sistema Nacional de Saúde*) which had been approved in October (Law no. 21-B/92), revoking the old law nr 9/75 which had proclaimed a totally socialized health care. The new law certainly determined that the health policy was based on the PHC, but also introduced a new system for financing the National Health System foreseeing the participation of the private sector. Its “General Principles” establish that the protection of health constitutes a right of each citizen, but that everyone is responsible for her or his individual health. The new law includes three important modifications:

- The authorization of private medicine and private pharmacies
- A legalization of charging patients for services (children below ten years of age in cases of emergency treatment and pregnant women are exempt from charges)
- A new orientation for the health system to pay attention to primary health with an important factor of decentralization and reinforcement of the role of the provincial level. (*Law no. 21-B/92*)

Moreover, the education system for health care staff should be totally reformed.

In November 1992, Sida also issued a Project Memo which announced a radical reorientation. The failed objective to reach out with PHC activities in the provinces and the rural areas was eventually abandoned after more than a decade of unrealistic hopes. The health support should be strictly concentrated, which was well in line with recommendations made in a comprehensive evaluation carried out in 1991. Furthermore, it should be transformed into an emergency programme. Objectives and goals had to be reformulated, and the support should be in the form of projects rather than sector support.

There seems to have been several reasons for the new mode of thought, among others that the administration of the whole Programme, with a huge number of TA staff, had become very burdensome for Sida. Therefore, the

idea of having most of the projects channelled and implemented by UN agencies or NGOs was brought up again by Sida in discussions about the future of the Programme. As could have been foreseen, this suggestion caused protests among the Angolans and was withdrawn.

The MoH based its negative attitude against UN implementation of the projects on the experiences through the years of the prolonged planning and decision process among the UN agencies and, thus, repeatedly expressed its preference for “classical” bilateral cooperation which was more transparent and manageable from the Angolan point of view.

Reduced support to training and planning

During 1993 the war escalated and Sida stated that the cooperation agreement could not be fully accomplished. Sida thus decided to limit the support to training, and to reduce the number of Swedish TA staff drastically.

The support to the Planning Unit in MoH was equally to cease in 1994. The motive was, formally, that other countries and organizations were willing to support planning functions in the MoH. One can, however, assume that Sida’s ongoing plans to outsource the whole Programme to an implementation consultant had an influence on this decision.

Angola and Sweden on different lines

Angola's proposal

Angola submitted a well-elaborated proposal to Sida for the period June 1994–December 1996, but the proposal did not entirely coincide with Sida's plans. It covered three areas:

- Sexual and reproductive health, including CAOL, training of midwives, family planning through UNFPA, HIV/AIDS, a maternal health project implemented by MSF-B in Kazenga district and collaboration with the Faculty of Medicine
- Prevention and treatment of endemic diseases, covering essential drugs and immunization
- General support, which includes administrative support and TA. (*MoH, 1994*)

In response, Sida suggested the present agreement be further prolonged. Sida agreed to include family planning through UNFPA and the MSF project in Kazenga, and it was already planned that the midwife training should start during 1996 with a substantial contribution from Sida. The *fifth agreement* for the period 1994/5–1997 amounted to 114 MSEK. At the same time Sida continues to prepare long-term plans for future cooperation.

A critical analysis – Sida identifies constraints

In November 1994, the Angolan government and UNITA signed another peace agreement in Lusaka. Even if there was a growing pessimism among most donors and other foreign observers, Sida had hopes to be able to elaborate a concentrated Cooperation Programme with a development perspective *in the near future*.

A comprehensive analysis was undertaken in 1995, which made Sida conclude that Sweden should support the ongoing transformation of the Angolan society in a democratic direction for national consolidation and social and economic development. Yet, the civil war and the macro-economic policy were considered two main constraints for such a development. A strong *political will* from the Angolan government to address the grave and complex problems in society was identified as a *sine qua non* condition for an effective

cooperation which could contribute to development and not only mitigate the emergency situation.

In other words, Sida requested good governance and a responsibility from the government to increase its budget contribution to keep the health system operational. Moreover, the problems with the centralized decision-making and management structure and the inadequate salary system for civil servants, and among them health personnel, must be solved.

Similar views were expressed in discussion papers produced in 1995:

The political will to address, among other things, the constraints referred to¹⁹ /.../ will be decisive for a successful planning and implementation of the future development programmes. The responsibility for the programmes must be more clearly indicated to be that of the Angolan party. The state's roles and functions in a modern society should be better defined. New policies, efficient laws and regulations such as up-dated laws on state enterprises and telecommunications and new labour laws should be elaborated.

/.../Angola is a rich country in natural resources and has substantial incomes from sales of oil products. The costs for rehabilitation, e. g. the basic facilities in health and education all over the country, are enormous. The country has in the first place to mobilize its own resources to address these problems since the international support will probably only be complementary and hopefully strategic in training of personnel and rehabilitating various facilities. /.../Strict conditions cannot be applied under the present circumstances, but development efforts must be assessed in the light of progress made. The costs for Swedish financing of various activities should be weighted against reasonably expected results and development programmes should be phased out if not meeting these criteria.

(Sida, Non Paper, May 1995)

MoH's self-criticism

In fact, the MoH elaborated a strategy paper in 1995, in which the steps to a modified Health System were outlined. In the paper the following weaknesses were identified, showing that theoretically there is conformity between the parties about the prevailing situation:

- The basic needs of the population, i.e. water and sanitation, nutrition, are not met.
- Immunization coverage is low and health services are declining.

¹⁹ The consequences of the civil war with disintegration of the state and the society, the macroeconomic policy, the necessary civil service reform and low institutional capacity.

- The government's health budget is extremely low.
- The training system for health staff is non-functioning and salaries extremely low.
- Parallel health systems, such as the public system, the military health system, the private health care and NGO projects are functioning without common guidelines.
- The Ministry's lack of guidance and planning (*MoH, 1995*)

However, this self-criticism was left without any reaction or comments from Sida's side.

The outcome: Focus on maternal health in Luanda

Concentration to the Luanda province

With the limitations imposed by the civil war, Sida in the mid 1990's made it clear that all activities had to be concentrated to the Luanda province, with the exception of human relief aid channelled through the UN OCHA system. Poverty alleviation and women's reproductive health must be given substantial attention in the future Cooperation Programmes. Thus, the support to the maternal health programme already in 1995 got more than double the resources compared to earlier years, and 20 MSEK was disbursed during 1995/96.

The support was mainly to be used by CAOL, which in reality was a coordinating and advisory board to the *Delegação Provincial de Saúde de Luanda* – DPSL (Provincial Health Delegation of Luanda). Its main task was to develop methods for improved management of the maternal health care in the province. More specifically, the objective was to improve the level of medical, administrative and technical competence among Angolan health personnel. Apart from coordination, meetings, seminars, and transfer of information, CAOL's role was to channel both Angolan and Swedish funds to different activities and institutions within the maternal health system in the province, but not to be actively involved in providing maternal health services.

The Programme outsourced to consultant

Since Sida had decided that the Programme should mainly offer transfer of knowledge and development of competence through training and advice from expatriate advisers; this “package” was considered a convenient service to be outsourced to a consultancy company, to solve Sida's problems with heavy administration and recruitment of TA personnel. After a tender procedure, that only marginally involved the Angolan party since all the documentation was presented in English, the consultancy company InDevelop was assigned to take over the Programme in August 1995. The Terms of Reference state that

Such assistance can be continuous on-the-job training, in developing of curricula and teaching methods and materials and in organizing and providing training of Angolan health staff, in particular midwives and obstetricians.

It was furthermore agreed that the consultant

...shall provide equipment, spare-parts, consumables and drugs indispensable for the implementation of the maternal health programme and to an extent which is appropriate in Angola both from an economical and medical point of view.

(Sida, Terms of Reference, June 1995)

CAOL and InDevelop were to agree on the scope and contents of the work to be performed, as well as a ceiling amount for fees and reimbursable costs, which means that the Terms of Reference could be given a rather flexible interpretation. Under the Coordinator of CAOL, the InDevelop administrator should coordinate the activities of all expatriate personnel.

The Coordinator of CAOL was responsible for the elaboration of annual plans of action, the implementation of plans and the follow-up of the activities.

InDevelop's duty was to present a *progress* report every six months and a periodic report on *results* within two weeks before every quarterly meeting with Sida. Apart from this regular reporting, Sida required a specific report on competence development and, moreover, InDevelop should submit a Final Report after the contract with Sida had come to an end. In sum, the number of reports increased, but the reporting undoubtedly became more systematic and result-oriented.

The cooperation between Sida and InDevelop seems to have functioned relatively well from the start. After one year Sida has only one complaint, namely that the Embassy has not been relieved from administration work as much as expected (*Sida letter, November 1996*). For some reason, procurement and customs clearance was still executed by the Sida office.

Explicit requirements of “services in return”

The specific health agreement, first signed in January 1994, was prolonged several times. When a new agreement was ready in due course in July 1997 it was very well prepared.

Early in the process Sida elaborated a framework highlighting certain concerns of the Swedish party. Sida communicated that the agreement should include requirements on “*radically improved services in return*”. It should be made clear that the agreement covered a transition period, and that the Angolan Government's actual achievements between 1997 and 1999 would affect future Swedish health sector cooperation in Angola. Financial sustainability was mentioned as a prerequisite, but the issue was not analysed more profoundly. (*Sida, Planning Memo, September 1996*)

In its country report 1997, the International Monetary Fund (IMF) stated that Angola's economic growth had been very strong during the 1990's, mainly because of the large offshore oil production, which was not affected by the war. The macroeconomic scenario was one of the background arguments when Sida started to emphasize the issue of financial sustainability, among other demands on the Angolan government.

Several assessment and project memos in 1996 and 1997 thus indicated a considerably harder attitude than in earlier negotiations between the parties. As an example, Sida stated that Sweden would pay special attention to and seek a close dialogue with the Angolan government on the following specific issues:

- The Government's general commitments and strategies for social development.
- The Government's actual allocation of resources to the social sectors in general and, specifically, an increased allocation for health.
- The actual utilization of the health budget, and the need for increased allocation efficiency.
- The development and adoption of a National Health Policy and Strategic Implementation Plan that addresses issues like structure of the health sector, human resource development and financing. (*Sida, Project memos, 1996–1997*)

The Swedish health sector support should remain concentrated and with focus on improving maternal and child health. The new support to child health should follow the same model as the maternal health programme, i.e. organize child health units at Health Centres in the peri-urban areas to relieve the pressure on the cramped Paediatric Hospital David Bernardino in Luanda.

Moreover, Sida stated that the Swedish response to emergency appeals shall to a higher extent be coordinated with the long-term development assistance, and the method of channelling funds through multilateral organizations should decrease during the period.

Obstacles identified

While Sida was proceeding with its analyses, Angola in 1997 submitted a project document for a two-year period and shortly afterwards Sida decided to draft an agreement for the period 1 July 1997–31 December 1999 based on the request. Sida mentioned that no evaluation had been carried out since 1991, but that the programmes seemed to be developing in a relatively positive direction. However, there were two concerns: the lack of impact on the policy level and the fact that Angola had not delivered its "services in return" as earlier requested by Sida. And although Angola's economy was growing,

the overall economic environment in the country was considered as a serious obstacle for development in the health sector. Sida's Project Committee²⁰ had even classified the low salaries and the tardy payment of health workers a "killing factor" of the Programme. Yet, the continued assistance was justified by the extremely bad health situation in the Luanda province. (*Sida, Results analysis, 1999*)

The *sixth agreement* contained support to six programmes. The support to the Planning Unit at the MoH had been phased out in 1994/95 as well as the support to family planning activities through UNFPA (United Nations Population Fund), but in this agreement one new component was added, namely the child health programme. The overall objective of the cooperation was formulated as improvement of health, especially with regard to women and children, by building up the capacity in the health system. Each programme had its own specific objective:

- The *maternal health programme* in Luanda should, through increased knowledge and improved capacity, substantially reduce maternal and perinatal mortality.
- The *immunization programme* aimed at preventing the most common diseases among children and women.
- The objective of the *essential drugs programme* was to reduce the mortality rate and to treat, in particular, the most common diseases in areas covered by the programme²¹
- The *AIDS programme* aimed at consolidating high quality HIV laboratory diagnostics as a routine service for blood transfusions and clinical work with more simple and less expensive strategies, both at central and provincial levels.
- The *midwife training programme* should establish a school for training of midwives
- The *new child health programme* in Luanda should improve health for children below 10 years of age through better paediatric services at all levels. (*Sida/MoH, agreement 1997*)

... and children's health added

The more specific objective of the new programme CAPEL (*Coordenação de Atendimento Pediátrico de Luanda/Coordination of Paediatric Care in Luanda*) was to diminish the flow of patients to the national Paediatric Hospital David Bernardino by an improved quality of diagnosis and treatment at PHC

²⁰ All programmes/projects are scrutinized by Sida's Project Committee, where representatives from different departments of the organization have a seat.

²¹ The Swedish bilateral support to the programme started already in 1985 but was channelled through UNICEF during the intensified civil war during 1993–95. In 1996 Sida re-launched its bilateral support.

level. CAPEL's target was to reduce the number of outpatients at the Paediatric Hospital to 70% of the actual 200–250 children per day. Easier access to child health at primary level, combined with rational use of drugs and increasing the immunization coverage should help building confidence in the communities.

Even though the principle of concentration was still in force at Sida's Health Division, CAPEL was seen as a logical complement to the maternal health programme through CAOL. Besides from Sida, CAPEL also received support from the EU and UNICEF.

More rigorous conditions

In the agreement, it was stated under the heading "Conditions for the Swedish Contribution" that all resources for the Programme not provided by Sweden should be allocated by Angola. In some cases these requirements were very specific, e.g. allocations for salaries for Angolan staff to be paid regularly to avoid absence from work because of health workers' necessity to be engaged in other income-generating activities, and allocation of budgets for recurrent costs for health facilities, e.g. cleaning material for maternity wards in the periphery and at the maternal hospitals in the city.

It was also stated that the parties should meet quarterly for review meetings, one of which constituted the Annual Consultations, and Angola should provide Sweden with different reports that are specified in the agreement.

The agreement thus included more requirements and conditions than the previous ones. To some extent this was explained by the fact that there were only specific agreements between Sweden and Angola at this time, since programmes in all other sectors had been phased out. However, it is obvious that Sida started to keep a closer and more critical watch over the health sector cooperation than ever before.

Systematic follow-up

Sida began reinforcing the follow-up activities of the Programme. In addition to InDevelop's reporting, a team of consultants was created for regular monitoring of the support. The monitoring process started before the Annual Consultations in November 1997, when the monitoring team visited Angola to discuss methodological issues. The team proposed a set of indicators to be used as a monitoring instrument by CAOL and also advocated bottom-up strategies in order to get an impression of the views of the beneficiaries and how they availed themselves of the programmes. From that on, the team made visits every sixth months which made it possible for Sida to methodically follow the development of the supported programmes.

The consultants confirmed that the weakness of the MoH and the health administration at provincial level raised stumbling blocks to substantial overall progress. The financial input by the Ministry was extremely low, which undermined the financial sustainability of the Programme. In a Country Results Analysis (1995/96–1998) Sida made a statement that turned out to be the beginning of the end of the cooperation:

One talks about *partnership* where both parties share similar values and wish to contribute to the development of the country and to improved living conditions for the population in distress. To a large extent, this is not the case in Angola.

(Sida, Results Analysis, 1999)

Thus, the Swedish party had a deep mistrust in and dissatisfaction with the lack of political will from the Angolan government, and there was also a strong feeling of frustration with the performance of CAOL. In a sector review meeting Sida expressed its critical views, declaring that the unclear leadership of CAOL hampered the development of the maternal health programme (*Minutes, February 1998*). The consequence was that Sida did not approve the annual plans for the coming year.

The poor management at the national maternity Lucrécia Paím Hospital continued throughout the entire year (1998). Consequently only 1 MSEK was used out of the 10 MSEK budgeted for the period. Sida's monitoring team suggested giving priority to activities at provincial level, i.e. in the suburban districts of Luanda, and that an evaluation of the Maternal Health programme should be carried out as soon as possible.

On the other hand, both CAPEL and the Essential Drug programme were developing well. The monitoring team made the interesting observation that the drug dealers at the parallel market complained that they had fewer customers than before.

Incentives to midwives

After Sida's support to CAOL had started 1989, it soon became clear that foreign currency and TA was not enough to attack the problems of the Maternal Health area. Midwives (and doctors) worked few hours per day – if at all – and the quality of care was below all acceptable levels, which was one of the reasons behind the high institutional maternal mortality. This outrageous situation was explained by low professional knowledge level among staff, bad management and an intolerably bad work environment, where drugs, equipment, instruments and even gloves were lacking. But most important – health staff could not survive on their meagre salaries in an economy where money, in reality, had no value. Midwives were usually surviving by doing home deliveries which they could charge for.

The proposed solution to reform the system was to start paying incentives to midwives at the hospitals and at the maternity wards in suburban Luanda. Incentive systems were practiced by multilateral and bilateral agencies in Angola, but not yet by Sida. In CAOL the idea was launched by the Swedish adviser, Dr. Britta Nordström, and, after some resistance, anchored in the Planning Department (Gabinete do Plano) of the MoH. The objective of the incentives was twofold: to improve the midwives' living conditions so that they could work full shifts and to motivate them to perform better at work.

Sida agreed to the incentives in September 1991. Criteria and rules were elaborated by the Planning Department and the Swedish adviser, and approved by Sida. (The same rules were applied when the consultancy company InDevelop took over implementation of the programme.) Initially, the system was planned to apply exclusively to midwives, but after some time it was extended to the management levels within the maternal health programme, to the training of midwives and the EDP.

Maternal wards have three shifts and the topping-up pay was set to 5 USD/shift. Midwives had to register in a special ledger and the Head Midwife of each ward was responsible to control presence. With the topping-up, midwives' salaries first doubled, but with an inflation of 800% per year the increase was 525% in September 1993. A midwife salary was about 1 Million Kz while a doctor made 2–3 Million Kz. With the incentives, a midwife could make up to 7.3 Million Kz per month, which was far beyond all other salaries in the public health system. This untenable situation created tensions and other programmes started to look at incentives as a threat to their own activities.

In October 1993, 136 midwives were receiving incentives. The total cost was approximately 1 MSEK per year. The management of the system was very cumbersome and time-consuming. After collecting attendance lists from all wards and approval by the Planning Department, Sida made the payment to a bank account. The CAOL midwife administrator and the Sida midwife adviser collected all the money in cash from the bank, which was not always easy since the bank sometimes refused to pay out USD in cash pretending there was not that much money available. The money was then brought to the midwife adviser's home, which was the only safe place. After counting the amount – the bank did not always pay the right sum – the money was personally distributed to each midwife.

Three consultants evaluated the system in 1993. They recommended a more simple system, above all to eliminate the risky handling of the money. The incentives should be gradually reduced, to be more balanced in relation to official salaries, and the system should be re-evaluated after some more years to study its effects on living conditions, work discipline and quality of work of the midwives.

In spite of the absurd details of the system, there is a general opinion that this salary supplement really had the expected positive effect among midwives at the small maternity wards and the maternity hospitals who were the primary target group, and consequently also positively affected their patients.

Sources: Åkesson et al. (1993) **Topping-up of salaries to midwives in Luanda, Angola**. Interview with Mrs. Kerstin Bertilson, Coordinator MoH, and Administrator InDevelop, and Dr. Anna-Karin Karlsson.

Questioning sustainability

In late 1998 the armed conflict escalated again. In November 1998, the monitoring team made its third review as part of the preparations for the Annual Consultations between Sida and the MoH. One of the issues to be explored in the review was the *sustainability* of the support, which four years later would come to be central in Sida's new health policy (2002). Further, the team was to discuss alternative strategies for the continuation of the support from the year 2000.

The team concluded that the support to maternal health in the Luanda Province was, in part, a success with a network of peripheral maternity wards for normal deliveries, a referral system to hospitals for complicated deliveries, some very strategic inputs at hospital level and a very strong supervision and reporting system. The Lucrecia Paím Hospital had now got a new management and capacity had improved. However, without external support, the maternal health programme had very limited sustainability.

Also the midwifery course (not yet an established school) was a cause of concern as it had started without giving much thought to its sustainability. The monitoring team therefore suggested to Sida to try and make the Angolan government (MoH and its Department for Human Resources) understand the need to take its institutional and financial responsibilities seriously.

One specific issue discussed in the monitoring reports was the more and more problematic incentives, i.e. the salary supplement for midwives paid in US dollars. At the time, nobody could expect people to live on the meagre salary of 100 USD or less per month, so to make health institutions and programmes function other solutions had to be found.

The basis of development cooperation reconsidered

New strategies required

Late in 1998, the monitoring team asserted that most, if not all, decisions regarding the cooperation between Sweden and Angola had been based on the assumption that peace was imminent and that macroeconomic stabilization was within reach. Such a development was no longer feasible:

However, the endless disappointments in this respect must now be taken more fully into account as a baseline for the analysis. /.../ we assume that the political and military conflict in Angola has transformed into a permanent situation, and that the establishment of a unified, and honest, government with a socially constructive agenda is beyond reach in the short to medium term.

(Johansson, Karlsson & Rylander, November 1998)

On the basis of these premises the team discussed three possible support strategies for Sida; “Business as usual”, “Humanitarian support” or “Exit Angola”. The choice was left to Sida.

Even if Sida did not overtly clarify which of the proposed strategies that was preferable to follow, the country analysis made a couple of months later clearly reflected frustration with the Angolan government (*Sida, Country Analysis Angola, 1999*). In this document, Sida stated that the development policy of Angola was not credible and that there were no preconditions for an effective cooperation with Angola. There was also a high risk for the programmes not being sustainable without Swedish inputs.

This view was confirmed in the Country Strategy for Angola published in May 1999. It concluded that the fundamental motivation for the health support must be humanitarian. The Programme should be of operational character rather than support to institutional and policy development.

Also the InDevelop advisers pointed at two important constraints clearly related to the lack of sustainability:

- The national health system was still very weak and the health situation for the majority of the population detrimental.

- The elaboration of a National Health Policy was permanently delayed. (*InDevelop reports, 1997–99*)

One common frustration among the advisers concerned the lack of will to *decentralize decisions*. *Decentralization together with increased influence from women's groups and organizations* are also later assessed as necessary preconditions for progress by the 1999 evaluation of the maternal health programme. Both aspects are in turn closely connected to the degree of sustainability.

It was, however, noted that the programmes seemed to function pretty well *with the external support*. The maternal health programme continued in a stable way and the family planning activities at the Health Centres were expanding, with particular attention to adolescents and young women. Also CAPEL, the essential drugs and immunization programmes as well as the National Blood Laboratory developed according to plans. (*Karlsson & Rylander, May 1999*)

It is also important to take note of some the positive trends underlined by the InDevelop advisors:

- The MoH had elaborated several documents with technical assistance from the World Bank, WHO and EU.
- The EU post-emergency programme was important as well as various NGO projects.
- The Italian Embassy was planning health support to the Luanda Province.
- UNICEF had switched strategy from implementing PHC to capacity building and to be the vanguard in launching the UN Convention on the Rights of the Child (CRC).
- UNFPA was focussing on capacity building at both central and provincial level and extension and decentralization of its activities to six provinces. The support included Family Planning Centres in Luanda especially for young people. (*InDevelop, September 1999*)

Humanitarian assistance – a short-time solution

In 2000, MoH submitted an application amounting to 46 MSEK for two years. Sida found the request to be in line with the recently approved Country Strategy for Angola for the period 1999–2001 and decided to provide MoH with the requested amount through a prolongation of the agreement in force. Around 30 MSEK should be used for Maternal and Child Health, 6 MSEK should be channelled through UNICEF for the Extended Programme of Immunization (EPI) and 10 MSEK was intended for continued consultancy services by InDevelop. (*Sida, Decision 2000-03-01*)

During the quarterly meeting between Sida and MoH, Sida informed that in the short term perspective the emphasis of the support was going to be on

humanitarian assistance, i.e. to activities aiming at people's survival. But the interpretation of this message seemed to have been a bit unclear, which may be one of the reasons why the same message had to be repeated also after the agreement was signed. In reality, it meant that the activities in the MCH area – CAOL, CAPEL and the midwife training course – were defined as “projects”, and that the long-term institution and capacity building aspects were downgraded.

“Business as usual” despite obvious strains

A *seventh specific health agreement* covering two years was signed on 27 June 2000. The demands on Angola were stricter this time than in the previous agreement. Besides rigid financial reporting, Sida required clear explanations of all deficiencies and deviations from approved plans. Disbursements might be withheld at any time if plans and budgets were not followed or if misuse of funds or other resources were taking place. “Annual audits” of the Programme is a new heading in the agreement. Previously, Angola and Sweden had agreed to include financial information in the final result analysis report. To some extent the stringent conditions could be explained by the fact that there was no longer any bilateral general agreement between Angola and Sweden since July 1999. However, the language definitely also reflected a certain weariness from the Swedish party.

When it was time to prepare for a new health agreement the situation and pre-conditions in Angola were unchanged. Furthermore, the Swedish Ministry of Foreign Affairs was elaborating a new Country Strategy for Angola. Therefore Sida's Africa Department commissioned the Health Division to prolong the present agreement for another 1.5 years with an addition to the budget of 35 MSEK (later increased to 36 MSEK). The original project memo with emphasis on maternal health, child health and immunization should remain valid. Efforts should be made to stimulate coordination between the programmes and to include HIV/AIDS activities (especially vertical transmission of the virus from mother to child). The contract with InDevelop should be prolonged without any tendering procedure. (*Sida, Assessment Memo, February 2002*)

Preparations for a long-term development agreement

When finally a real peace process takes off in Angola, after the Luena Peace Accord in 2002, optimism is awakened and Sida stated that the coming new Country Strategy for 2003–2005 opened possibilities to continue the support to the health sector. A permanent peace would make it possible for the government to allocate more resources to the social sectors and to reach out with health care to the whole country. (*Sida, Assessment Memo, October 2002*)

Nevertheless, Sida identified remaining obstacles, such as lack of political will, lack of a national health policy, and lack of horizontal integration between Sida-supported programmes and activities implemented by the Provincial Health Directorate of Luanda or the MoH. These factors posed a serious risk of jeopardizing effectiveness and sustainability. But in spite of obstacles and risks, Sida's Africa Department saw the peace scenario as an opportunity for Angola to restart with institution building, formulation of a health policy and reforming the health system and, eventually, to make it possible to improve the health situation in the country. When planning for a new agreement, Sida should take into consideration how to transform the present humanitarian aid into a Programme for long-term development.

Thorough knowledge emphasized

For the first time during the long period of support to the Angolan health sector, Sida decided to make a fundamental analysis of the pre-conditions to be fulfilled before embarking on a new agreement. For this purpose Sida set aside 2.2 MSEK for an evaluation and for the rest of the planning process. (*Sida, Assessment Memo, October 2002*)

The connection between the outcome of Sweden's Country Strategy and the cooperation within the health sector was never clarified, which resulted in a lot of misunderstanding and mistrust. Much indicates, for example, that the author of the Assessment Memo took it for granted that the Strategy would suggest continued cooperation within the health sector.

While the Country Strategy process was going on, Sida created a working group to prepare for a project document for the next agreement. It was decided that the process should start with reviewing the experiences from the cooperation during the last few years.

The issue of sustainability had come up several times during the past years and was a concern both to those directly involved in the Programme and to the administrators at Sida. A major purpose was therefore to assess the maternal and child health programmes from a long-term sustainability perspective. Another aim was to produce recommendations that could be used in the preparation of the new agreement.

The evaluation should be carried out in 2003 by external consultants. The evaluators observed that some parts of the maternal health programme could be considered sustainable, while others were not. Beside availability of financial resources, the degree of sustainability was connected to a number of factors, e.g. the degree of decentralization of decisions and resources. In this respect both CAOL and CAPEL were developing in the right direction. In sum, the evaluators concluded that there were shortcomings but also possibilities for the Programme to survive with less external support. (*Karlsson, Salmonsson & Challis, Sida, 2003*)

With reference to the *draft* Country Strategy that was anticipating a continuation of the health support beyond 2003, the Swedish Embassy in Luanda²² in February 2003 decided to take further steps in the preparations for the next agreement period 2004–2006. (*Sida, Decision 2003-02-24*)

A new turn

However, on 3 April the Swedish government adopted the Country Strategy, which in its final form concluded that the long-term cooperation within the health sector in Angola was to be phased out:

The present agreement is valid until the end of December 2003, and after that a concluding agreement can be established to phase out the health support within the present strategy period.

The conditions for future bilateral long-term development cooperation shall depend on the development policy of Angola's government and its financial needs. Only if necessary conditions are met can long-term development cooperation come into question.

(*Min. Foreign Affairs, Country Strategy, 2003, p. 19*)

The Strategy provided concrete guidance on what the country programme might include during 2005, indicating what channels to be used. A clear focus of the Country Strategy was democracy and human rights. The new instruction was to limit Sida's humanitarian support to emergency interventions in a stricter sense, while support for the important work of some UN agencies and NGOs through non-earmarked contributions would have to be discontinued.

The official motivation of the phasing-out of the health support was that Sweden was going to put a strong emphasis on support for the consolidation of peace, democracy, human rights and the role of civil society and that ways to broaden the cooperation would be sought.

Audits and frozen disbursements

During spring 2003, a financial audit was made of the midwife course in Luanda and some minor faults were detected. Meetings were held between the management of the course and the Embassy in July.

The Embassy's preparations for a new health agreement beyond 2003 ceased temporarily. A project proposal was, however, elaborated by the MoH in May according to the Country Strategy and the Embassy resumed the preparatory procedures. In August 2003, the project was submitted to Sida's Project Committee.

²² Development cooperation through Sida is integrated in the Swedish Embassy since the 1990's.

In October the same year, the audit was extended to the health programme as a whole and the auditors reported further faults, although of a relatively trivial character. But the Embassy took the auditors' report seriously and stopped the disbursements to the Programme in December and decided to postpone the signing of a new agreement until the DPSL and MoH had rectified the irregularities encountered, but since the report had to be translated into Portuguese the Angolan project managers only received the audit in February 2004.

During the void, without any agreement and with disbursements frozen, the MoH, project managers and InDevelop worked on the recommendations made by the auditors. In May 2004, the Planning Department of the MoH informed the Swedish Embassy in Luanda on actions undertaken or to be undertaken as a result of the audit. The Embassy concluded that the proposed actions were adequate and recommended that the preparations for a new agreement be finalized. Sida agreed and decided that the preparation should be finalized by Sida's Health Division. (*Sida, Decision, May 2004*)

Last agreement – sustainability in focus

In an assessment memo dated 28 May (!) for the period 1 June 2004–31 December 2005 matters focused on the support to building systems, structures and capacity in order to make it easier for Angola to continue the activities without any support from Sida after the end of the cooperation. Reference is made to Sida's Health Policy from 2002, which says that Swedish international development cooperation shall support countries to achieve “*sustainable and effective health systems and increased access to and coverage of health services of acceptable quality, emphasising social equity and gender equality*”, which is considered to be relevant in Angola's case. The focus on improved health services especially targeting women/mothers, children and adolescents is consistent with Sida's policy. The assessment memo also mentions that the project, under its last phase, will make increased efforts to involve men/fathers in family planning and try to reach young men through the special family planning services (at Health Centres) for young people.

The postponed agreement, defined as the final one, was finally signed and should cover the period 1 June 2004–31 December 2005. It amounted to 44.5 MSEK and it was agreed that the funds should be used in accordance with the Angolan Project Document, dated May 2003 as amended in writing from time to time. The contract with the implementing consultant InDevelop, was signed for the same period (8 June 2004–31 December 2005).

The agreement specifies Angola's obligations, and among other things, states that:

... since this will be the last agreement, Angola should suggest and give alternatives to the [present] funding of the programme

from 2006, to assure its sustainability. Especial emphasis should be given to funding alternatives for those services at Reproductive and Child Health Units that depend on the Provincial Directorate of Health of Luanda. Since it is foreseen to make several investments during this last agreement, maintenance of these investments must be assured through [the budget for] recurrent expenses. *(Embassy of Sweden/MoH, Agreement, June 2004)*

The main objective of Angola's project *Projecto de Saúde 2004–2005 MINSA-Asdi* (Health project 2004–2005, MoH-Sida) is

... to contribute to a better health for the mothers and children who live in the Luanda province. The specific objectives are to:

- Improve the quality of the existing services
- Expand the basic health services to make them available to the whole population (of Luanda)
- Improve the knowledge and competence of the health staff
- Improve the integration of programmes and services
- Strengthen the planning and management capacity at the Provincial Directorate of Health, at the health sections of the municipalities, and at the peripheral health units, thus assuring the sustainability of the health activities. *(DPSL, Projecto de Saúde 2004–2005 MINSA-Asdi, 2003)*

Sida and DPSL agreed to establish an Exit Strategy, which was integrated into the comprehensive Operational Plan for 2005. This exit strategy was actually already outlined in the Project Document produced in 2003, and was well in tune with the principles later described in Sida's assessment memo 2004.

During the months when Sida's disbursements were withheld, some of the planned activities had to stop, while regular work went on as usual, but at a lower pace. The exception was the midwifery course, which could not be run without resources, since many students came from other provinces and could not be kept waiting in Luanda or return home because the course was interrupted. This troublesome situation was solved by the Human Resources Department of the MoH, whose director was whole-heartedly engaged in the ongoing reform of the training system for health staff, where the midwifery course is an important component. The Ministry simply took over the financing of the course, which consequently could continue without interruption.

In the beginning of 2005, Angola had an outbreak of Marburg fever which caused another delay in the implementation of the programme. All health staff was mobilized to combat the Marburg epidemic, and the MoH and

DPSL presented an application to Sida applying for an extension of the programme and its funding for six months. Sida agreed to prolong the agreement to three months, i.e. until March 31, 2006.

Tendencies in 2006

For obvious reasons it is far too early to make any judgements, or even to speculate, about the sustainability of the Sida funded projects in Luanda province. During the last couple of years the Health Sector has been receiving more funds from the State Budget, in absolute terms, although not in percent of the budget, since the volume of State Budget has doubled as a result of the peace and increased revenues from the oil sector. Angola has also been granted a 4 billion USD credit from China, which is used for huge infrastructure investments, but according to some sources also partly channelled to the social sectors. It is, however, important to underline that budget appropriation figures in Angola are not equivalent to real allocations, since normally only a part of the budget is allocated for employment by the ministries.

While DPSL complains about its unsuccessful bargaining with the provincial government for an increased budget for 2006, using Sida's exit as an argument, the former provincial Maternity Hospital Augusto N'Gangula has been classified as a General Hospital, which implies that its funding comes directly from the Ministry of Finance, without passing through the MoH. The Lucrecia Paím Hospital and the Paediatric Hospital David Bernardino are national referral hospitals, and equally receive their funding from the Ministry of Finance. This is naturally a guarantee for a minimum financial sustainability, but will probably not cover deserved improvements with regard to the care of mothers and children in the worst health conditions. But the province's health budget has at least been alleviated with one hospital less to cater for...

The midwifery course is for the moment in safe hands, but currently the Province government has 24 Health Centres with maternity wards and 29 Health Centres with emergency room for children. This structure will need not only funds for investments and running costs, but recurrent staff training and good managerial capacity to keep up the present quality level and, at best, improve it.

Part 2: The Angolan point of view

Angolan voices – the evaluation 1991

One important objective of the evaluation of the health programme made in 1991 was to collect views from different categories of actors involved. An Angolan team was formed with the aim of capturing the views of the Angolan part “from the inside”, a perspective that was considered essential when planning for the continued cooperation.

During the preparation of this study we have found that the Angolan part of the evaluation²³ got very limited circulation and was hardly analysed in Luanda. We doubt that Sida staff read it, or at all became informed about the recommendations made by the author. We thus decided to highlight this Angolan testimony, which reflects the situation of the programmes as well as the cooperation as such. (A summary of the evaluation report can be found in *Appendix 3*.)

The Angolan team collected the opinions not only from people in leading positions but also from different categories of health workers in the field. Almost a hundred persons were interviewed: 47 at central (national) level in Luanda²⁴, 28 persons belonging to the provincial health institutions in Luanda and 22 in Huíla. A typical phenomenon is that virtually all interviewed central programme staff in Luanda were doctors while in Huíla the only doctor was the Provincial Delegate – all the visited Health Posts were run by female and male nurses and all persons in charge of the programmes were (male) nurses.

The team used a very extensive questionnaire, which included issues such as objectives and target group, planning and management, relation to Sida, Swedish *cooperantes* and their performance, etc. The ten interviewers – mainly doctors or medicine students, but also some economists – talked to staff in all programmes which had Sida support at the time²⁵, namely:

Essential Drugs – EDP

Extended Programme
of Immunization – EPI

General Support

Health Education

²³ The Swedish evaluation report was translated into Portuguese in 1992.

²⁴ Mainly the same persons as in the Swedish evaluation made by Dr. Lillemor Andersson-Brolin and Dr. Anna-Karin Karlsson.

²⁵ The support to the nutrition and water/sanitation programmes had already been phased out in 1985.

HIV/AIDS

Malaria

Maternal and Child Health – MCH Training

Trypanosomiasis

Tuberculosis – TB

Recommendations for future development

The recommendations made by the author of the report, Dr. Rui Pinto, seem mainly to be directed towards the MoH, but were also very relevant for Sida and are also reflected in the Swedish evaluation, especially with regards to the efficiency and outreach of the programmes. But many of the tangible proposals below could have been a basis for Sida to initiate discussions with the MoH in order to improve planning and management and include more training components both at central and provincial level, to help run the programmes more smoothly.

- An important suggestion is to continue training of staff at all levels, to guarantee continuity, stability and quality in the future development of the programmes. There is also an evident need for a seminar to create a common understanding of the Public Health concept, so that health staff from the centre to the periphery starts speaking the same language. In addition, the author proposes another exercise to teach planners and other staff the difference between programmes and projects, planning concepts like objectives/targets, resources/costs and efficiency/effectiveness, since most of the interviewees were quite confused regarding these aspects of their own programmes.
- Some programmes need revision, and there is also a need to elaborate some new programmes, and this should be done with a uniform methodology, so that such processes as planning, organization, management, supervision and evaluation could involve and be understood by everybody. Moreover, the author questions whether it is at all advisable to maintain programmes that are totally dependent on external support.
- The whole budget planning needs improvement, in what regards the Kwanzas budget as well as the budget in foreign currency. The financial management process, with budget follow-up, financial statements, etc., should be thoroughly revised, to make it possible in the future to evaluate efficiency and effectiveness of the programmes.
- There is also an urgent need to study possible methods for coordination between the programmes, so that they can form part of a fully integrated Public Health Care system. This would also lead to a better use of the existing resources of the different programmes.
- A crucial point is the rotation of staff within the MoH structures, which affected the programmes negatively. To avoid this, the promotional system needs to be improved and it should be possible for the staff to be upgraded and appointed accordingly.

- When programmes are evaluated, it is important that this is done in a way that is useful for the development of the programmes. This could be done through the involvement of the Angolan party and by trying to use the conclusions as a diagnosis of a concrete situation that needs improvement.
- Last, but not least, the author emphasizes that the infrastructure needs attention, especially that of the Health Posts. Not only the sanitary conditions need improvement, a lot more needs to be done to ensure these small units achieve the real standard worthy a health institution.

Diagnosis of the main health problems in Angola in 1991

The inquiry form used by the Angolan team included an open space to invite the interviewees to mention the most important problems in the health sector according to their personal view. 52 people gave their contributions, which were compiled by the author of the report.

<i>Problem</i>	<i>No. of references</i>
High levels of morbidity and mortality caused by endemic infectious diseases	42
Administration and organization of health services and management of resources	29
Incorrect preventive activities, deficient environmental sanitation measures and insufficient water supply	27
Problems connected with the health policy in the country, with the legislation in force, with the [low] quality of provided health care, with the low access to PHC or non-application of PHC	19
Incorrect professional training and upgrading of staff, both with respect to quality and quantity [no. of trained staff]	14
Too little attention paid to mothers and children, resulting in high maternal and infant mortality rates	14
Health problems caused by lack of food, resulting in malnutrition among the population	14
Health problems caused by the socio-economic situation in the country aggravated by the war	12
Health problems due to the low educational level of the population and the low impact of the Health Education programme	8

Source: Pinto, R. (1992) Avaliação Especial do apoio ASDI a Programas de Saúde da R.P. Angola. Opinião da Parte Angolana. Dezembro de 1991 e Janeiro de 1992.

Part 3: Angolan and Swedish views on the programmes

We will now turn our focus on the different programmes supported by Sida. In order to complement written information, Angolans and Swedes involved in the programmes at various times were interviewed. Our main aim is to reflect the experiences on both sides during the active bilateral collaboration, from an institutional as well as personal point of view. It is natural that such an exposition has certain limitations, since the field is wide and the study extends over almost thirty years, and many details and aspects are necessarily left out. We will, however, give a brief account of what happened to the programmes that had Swedish support. Did the programmes survive and how did people involved in the programmes experience Sida's phasing out its support?

Essential drugs

In the 1980's Angola tried to establish a national production of essential drugs, but it soon became clear that such a project was not economically feasible – imported drugs were in fact less expensive. So, from 1986 and for fifteen years to come, import of essential drugs was one of the most important components of the health support. The Sida support covered drugs for Health Centres and Posts in seven provinces, and was one of the programmes that had Swedish technical assistance during six years for support to the pharmaceutical and medical areas, since the programme had an important training component to improve diagnostics and the rational use of drugs. The logistic area, which included the central warehouse, also had specific technical assistance. Permanent technical assistance was phased out in 1993, but the programme has had support through InDevelop consultants from time to time.

In 1985, Dr. Anna-Karin Karlsson was working as a primary health adviser and she tells her version about how essential drugs came to be part of the Sida programme:

I was going home to Sweden on holiday, when Dr. Feio, who was the head of the Planning Department in the Ministry, asked me at the last minute if I could make a list of some basic drugs. There was some money left of the budget and with Sida's authorization it could be used for importing these drugs. I made the list, and left. In Stockholm I was later contacted by the Health Division at

Sida. They wanted me to come and discuss a proposal from the Ministry to import drugs. I recognized the list, and said that I thought it was a good idea to go ahead with the purchase.

(Personal communication, 2006)

The programme soon got a considerable budget from Sida, since the country was in desperate need of drugs and probably also because the purchase of drugs could absorb a good deal of the total budget. The overall objectives were (and still are):

- Regular distribution of essential drugs to PHC units, and
- Rational use of drugs, mainly with reference to diagnostics and treatment

In the beginning the organization of the programme was not very well established and there was not enough qualified staff to handle the rather complex activities. The five Swedish advisers who worked with the programme during different periods from 1986 to 1992 all agree that the programme has a lot of complicated problems to solve, but that the chances are that a much better level of efficiency can be reached.

The warehouse is one of the big problems, which cannot be solved by a single Swedish logistician. He tells a rather sad story about the *Depósito Nacional de Medicamentos* (the National Warehouse for Drugs):

The warehouse is a former coffee warehouse. These premises were thus built to maintain a high temperature, and for this reason alone the warehouse is totally inappropriate for storing pharmaceutical products. /.../ Electricity is installed, but is usually not functioning. There is no water, and no transports and canteen for the workers. /.../ Work discipline is very low, and presence often just a formal 'marking'. The workers can only survive economically if they steal drugs. This is made easier thanks to a control system completely devoid of transparency. Since everybody, from director to cleaners, is eager to maintain a non-functioning stock and control system, it is very difficult to introduce such a system. In my job description one of my tasks is to 'create a better order' in the warehouse, but this has not been within the range of possibility.

(Karlsson, June 1990)

After describing a series of other difficulties with the complicated purchase system through Sida, distribution to the provinces, maintenance of vehicles, etc., Mr. Sören Karlsson concludes:

My report became much more negative than I had intended. But everything is not as black as night. Problems really need to be discussed and solved. It is also difficult to see progress in the short term. On the credit side, however, one should note that practi-

cally all Centres and Posts in the parts of the country where the programme is active do in fact receive their kits and this happens rather regularly. This fact alone makes a big difference compared to 2.5 years ago. According to available data, 25% of Angola's population today have access to drugs through the EDP. These facts are easy to forget when all problems are piling up.

(Karlsson, June 1990)

One of the medical advisers directs his main critique against the directors in the MoH, who show a total lack of commitment to the programme, since they are *"more interested in arranging benefits for themselves than helping the big majority to get a better life"*. This is however not the case of the programme directors, who have shown a big interest in producing results, and the new director has a management style which is positive for the development of the programme.

In the provinces the attitude towards the programme is totally different, compared to that of the MoH. There is a genuine interest to make the programme function and develop, although the competence level is rather low. To increase knowledge and raise the level of efficiency, the programme organizes training activities, with seminars on the rational use of drugs, etc. Manuals have been produced, but it can take time before they reach the provinces – the one about treatment of frequent diseases got stuck in the MoH for four years after it had been revised by the programme. Regular supervision visits are done by the Luanda staff, which is also important for province staff and for feedback to the programme.

An evaluation commissioned by the MoH and Sida in 1990 included a study of patient management in three provinces. The study showed that only 12% of health workers had the necessary skills to assess, diagnose and give the proper treatment. The study recommended regular refresher courses for health workers at Health Centres and Posts, backed up by frequent quality supervision.

Refresher courses should be instituted, and the resources for them provided. A supervision system with clear objectives and with incentives that motivate good performance, is an area that requires urgent consideration.

(Björck, et al., 1992)

These results made the programme management strengthen the training component to give it more or less equal weight in the programme as the distribution of drug kits.

Although essential drugs are supposed to be free of charge at Health Centres they are often sold, although at cheaper prices than in pharmacies. Sida's monitoring team²⁶ made a small survey of prices of some essential drugs in November 1998.

²⁶ Dr. Rolf Johansson, who had been adviser to EDP, Dr. Anna-Karin Karlsson and Mr. Lars Rylander.

Table 5. Prices of essential drugs²⁷ in Luanda. Kz, 10 tablets. November 1998

	Maianga Health Cent.	Terra Nova Health Cent.	Prenda Pharmacy	ECOMED Pharmacy	Parallel Market
Aspirin	300	300	800	2,750	500
Paracetamol	300	300	800	1,710	500
Chloroquine	300	300	800	3,230	1,000
Iron tablets	300	300	800	2,230	1,000
Amoxiciline	1,000	1,500	2,000	1,650	1,500
Cotrimoxazole	-	500	800	4,220	1,000
Mebendazole 6	300	300	800	2,600	500

Source: Johansson, Karlsson & Rylander, November 1998.

The illegal sale of essential drugs at Health Centres is only one side of the generalized practice of charging for different services within the health system, which has been in use for a long time. It has the form of *gasosas* (“soft drink”) charged by nurses and midwives, and the patients are often also forced to buy gloves, syringes, etc. which are first stolen and then sold by the health workers.

One of the problems affecting the programme is the lack of National Policy of Pharmaceuticals, which is still not resolved (2006). A document has been elaborated with support from Swedish experts (consultants) through a rather participative process. The document was presented late 2005. Since pharmaceuticals constitute both a complex and controversial area with big economical interests involved, the policy has been the victim of the internal politics of the MoH and has until now not been approved by the parliament. In spite of this political vacuum, the old national producer of pharmaceuticals, Angomédisa, will soon reopen, but now under private management.

The EDP is one of the most successful of the programmes supported by Sida. The present Directors, Dr. Jorge Manaças and Dr. Constâncio João, have both been working with the programme for almost twenty years, which has given a considerable stability to the activities. Sida phased out its support in the year 2000, and what happened then?

Our programme has been resisting. But we had one year when we really felt like orphans after Sida had left, because no other donors appeared. But in 2001, we started to get funds from the government and we could gradually start importing again. And today we get more funds than ever before, so for 2006 we have got 8 million USD and cover all the provinces.

²⁷ Analgesics/antipyretics, anti-malaria tablets, ferrous salt tablets (iron supplement for pregnant women mainly), antibiotics and de-worming tablets.

Today we distribute the kits through private transport companies. The programme never had enough trucks and we got help with the distribution from WFP. Today it works well, because the private companies perform much better than the state and they must fulfil the obligations of the contract. One of our staff always accompanies and is responsible for delivering the kits at the respective Health Centre or Post.

The provincial supervisors make regular evaluations of the use of drugs, but we have difficulties in acquiring funds for these “soft” components. Importation and distribution are no problem, but for training and seminars it’s a headache. This was included in the Sida budget, and it was much better. We really need to offer training, because the rational drug use remains a problem, although it varies from province to province.

The fact that the programme still exists today has to do with the seeds that were sown by the Swedish support. A complete programme was built up, and it has credibility. And we have no complaints about the technical assistance.

(Personal communication, 2006)

Today the programme has support from EU, but sustainability depends on government funding. And the government must continue funding. People complain when they cannot get the drugs prescribed, and complaints reach the highest political level.

Extended Programme of Immunization

The EPI programme dates back to 1976 when Angola together with UNICEF initiated the first collaboration plan for an immunization programme. Immunization is emphasized as one of the main pillars of the primary health care system, and it was one of the first areas to receive Sida support in 1979.

EPI has always functioned as a vertical programme and very often used big immunization campaigns to reach out. The objective of the immunization programme is to reduce infant and child morbidity and mortality from six vaccine preventable diseases: TB, diphtheria, whooping cough, tetanus, polio, measles and yellow fever.

Vaccination is given to children under one year according to the following schedule:

- At birth: BCG vaccination against TB and the initial dose of oral polio vaccine
- At 2 months: 1st dose of DPT (Diphtheria, Pertussis/Whooping Cough, Tetanus) and the 1st dose of polio vaccine

- At 4 months: 2nd dose of DPT and the 2nd dose of polio vaccine
- At 6 months: 3rd dose of DPT and the 3rd dose of polio vaccine
- At 9 months: One dose each of measles vaccine and yellow fever vaccine.

The EPI programme also includes the vaccination of women during pregnancy with two (or three, if not immunized before) doses of Tetanus Toxoid (TT) vaccine, to protect the new-born infant from neonatal tetanus.

Low coverage

Immunization coverage remains low in Angola, although EPI has been operating for forty years. After the heavy rains and flooding in Luanda 1984 the EPI organized a successful campaign which made it possible to keep measles under control for a couple of years. The number of cases of neonatal tetanus was also reduced through that effort. An evaluation by an international team in 1986 and 1989 showed, however, that the programme reached more than 80% of children with the first vaccination, but that less than 10% of eligible children in Luanda were fully protected with all the vaccines. This was far from the set target of 75% and the programme reduced its target to 40%, which was considered a more realistic level.

The *Instituto Nacional de Estatística* (National Institute of Statistics) has carried out a series of national cluster surveys, Multiple Indicator Cluster Survey (MICS)²⁸, which are considered to be the best source for health data at national level. We have access to data from three MICS and the results show that vaccination coverage is still very low.

Table 6. Percentage of immunized children, 12–23 months old

Vaccine	1997	2001	2005
BCG	59.5%	68%	69%
DPT 3	23.9%	34%	34%
Polio 3	27.5%	41%	63%
Measles	45.5%	64%	54%
Complete vaccination	16.7%	26%	27%

Source: MICS 1997, 2001 and 2005.

The relatively good coverage of BCG vaccination is explained by the tradition from colonial times to bring a newborn child to a Health Centre to get antitetanic serum, which gives an opportunity to immunize the child against TB. The 1997 MICS shows a big difference between urban and rural areas

²⁸ This type of cluster surveys is done using a standardized random sampling technique and gives fairly accurate information about immunization coverage in a population. Surveys are justified in countries where population data and routine reporting is unreliable and/or incomplete.

– in the rural areas only 9.5% of the children below two years of age had received complete vaccination protection.

The other, and more official information source, is the reported immunization at Health Centres and Health Posts. Based on these routine reports, vaccination coverage is calculated using the estimated target population in the geographical area served by the health unit.

Data from the routine reporting system show higher coverage and also confirms the high initial contact with the first doses which is an indication of “access” to immunization services. Similarly, the data from routine immunization show high drop-out rates between the first dose and the subsequent doses.

Table 7. Immunization data from Health Units in Luanda

Vaccine	1998	2000	2002	2005
BCG	68%	46%	91%	99%
DPT 3rd dose	45%	38%	48%	63%
Polio 3rd dose	44%	38%	50%	61%
Measles	38%	33%	48%	53%

Source: DPSSL.

Neonatal tetanus

Immunization of pregnant women with two doses of tetanus vaccine has, according to the routine reporting, a low coverage. From 1998 to 2002 approximately only 30% of the pregnant women were vaccinated in Luanda. In 2005 the figure had improved to 46%. This still leaves more than half of the pregnant women unprotected, which is reflected in a continuous number of neonatal tetanus (NNT) cases in infants. It should be noted that the routine data only covers pregnant women that visit Health Centres for antenatal care, which means that there is a large percentage that is not immunized, since Health Centres in reality do not know the population in their catchment area. There is also no system which makes people in a district “belong” to a specific Health Centre, which makes it difficult for health staff to follow up on immunization and antenatal care.

A study made at the Paediatric Hospital David Bernardino in Luanda (*Acta Médica Angolana no.1/2005*) shows a quite deplorable situation regarding NNT in Luanda province. The disease has been eliminated in most developing countries, but among the 57 countries where it still exists, 90% of all cases appear in 27 countries of which Angola is one. In 1985 more than 1,000 cases were reported in Angola, 2002 more than 600 cases and in 2004, 195 cases. During the period January 2002 to June 2005, the Hospital reported 504 cases of NNT of which 454 died. When the mother was fully

immunized (three doses of vaccine) none of the babies died, while the mortality was 79% although the mothers had received two doses. This is explained by the fact that most of these children had been born at home under very primitive conditions. The section of the umbilical cord had not been made with scissors, and the navel was treated with traditional mixtures of ashes and oil of different kinds. Babies whose navel had been disinfected with alcohol had the best chance to survive – “only” 10% of them died. In Angola neonatal tetanus remains one of the important causes of mortality of new-born infants, and the most effective method to reduce NNT mortality is the full immunization of young girls and pregnant women, since it will take generations before conditions for safe deliveries exist in the whole country.

Immunization campaigns

In addition to the routine vaccination at Health Centres, there has been an increased emphasis on mass vaccination campaigns during the last five years. The focus has been on polio eradication and the vaccinations are targeting children under five. During recent years Measles vaccination has also been included in campaigns. This is also the case in 2006, when a campaign, *Viva a Vida com Saúde* (Enjoy a Healthy Life) took place in July–August. The target of the campaign was 3.5 million children who were receiving measles vaccine, oral polio vaccine, de-worming medicine, vitamin A and mosquito nets for the families.

The impact and consequence of campaigns have been discussed in several reports. Campaigns can never substitute a routine vaccination programme. From the Swedish point of view, it has often been emphasized that campaigns are expensive and draw resources and attention from the routine activities. Some critical voices hint that the campaigns are popular because they mean money for many professionals involved. However, the Angolan official position seems to be pragmatic and argues that campaigns can mobilize people and bring attention to the need for immunization. Besides, the Angolan programme managers do not have a choice since donor funds are often conditional to campaigns.

Disease control

Poliomyelitis cases are few. As part of the polio eradication effort all cases of flaccid paralysis are to be reported and investigated. The last “outbreak” of poliomyelitis in Angola was in 1999 and was reported as one of the largest epidemics in the vaccine era and one of the largest polio epidemics in Africa. During 2002 and 2003 no cases occurred but 33 cases were confirmed in 2004.

Evaluation of the Immunization Programme in Luanda

In February 1993 an evaluation of the Immunization Programme was carried out in Luanda. 37 out of the 52 existing vaccination posts were visited. The evaluation showed that the existing network of vaccination sites were relatively well established and equipped with sufficient cold-chain devices but there was a lack of sterilization equipment and syringes and needles. The quality control and monitoring of the cold-chain was not up to standard. According to UNICEF, sufficient quantities of equipment had been distributed. A possible explanation to the "waste" is that syringes, needles and sterilization equipment were theft-prone objects attractive on the market. There were enough and trained staff but in most Health Centres opening hours were limited to a few hours in the morning.

<i>Activities</i>	<i>Well-functioning</i>
Refrigerators	81%
Monitoring of cold-chain	25%
Sufficient vaccines	80%
Sufficient syringes and needles	25%

The reporting system was based on simple "tally-sheets" where vaccinations were recorded and the reports done and submitted to the programme managers. The problem was that the number of given vaccinations have to be related to the total number of children in the specific area where the Health Centre was situated. Very few vaccination centres had reliable population data and vaccination coverage information was therefore not reliable.

The epidemiological information about the target diseases was virtually non-existing. As part of the evaluation, an analysis of registered cases of measles at the Health Centres was done. The relatively high proportion of cases that had been vaccinated raised the concern about poor vaccine efficacy due to inadequate cold storage. During the following coverage survey, blood samples were collected and analysed for antibody response to measles vaccines. The result showed that the measles vaccines given had acceptable quality and did not confirm the previous concern about low vaccine efficacy.

A follow-up study was done in Luanda in April the same year to assess the real vaccination coverage among children <1 year and pregnant women. The method used was the WHO standard cluster survey. The result showed that 90% had got their first vaccine but only 50% had got the measles vaccine and 30% had been fully vaccinated.

Similar vaccination coverage surveys have been carried out in Luanda since 1981, and show that vaccination coverage has improved from 1981 to 1989. Since 1990 the vaccination coverage has stabilised and measles vaccination has dropped slightly. This pattern is similar to other developing countries. A programme can reach 50% of the population relatively easy but to further expand coverage and stop transmission of the disease demands greater programme involvement.

Measles outbreaks occur regularly in Luanda. In Kazenga, the most densely populated district in Luanda, there was a measles outbreak with 300–350 cases/month in May–July 1993. With low vaccination coverage this did not come as a surprise. The NGO MSF was working in Kazenga and suggested an epidemiological study of the outbreak and an evaluation of the immunization coverage. UNICEF, on the other hand, argued that the information available was sufficient and that all resources needed to be concentrated to improve and expand vaccination. Unfortunately the national programme managers did not have the power and authority to take the lead, the strongest donor set the agenda.

Staffan Salmonsson, PHC adviser in Luanda 1992–93

In Angola outbreaks of measles are reported from some parts of the country each year. According to the Angolan director of EPI there have been less measles cases during the past years. In 2002 almost 15,000 cases were reported, 2003 just over 3,000 cases and 2004 only 600 cases were reported in Angola.

Health education

The Health Education programme is under the administration of the MoH National Directorate of Public Health. Sida started supporting the activities in 1986, with 4.2 MSEK, which was increased to 5.8 MSEK in the next agreement in 1989. The support was phased out in 1993.

The objective of the Sida support was mainly to strengthen the programme institutionally through technical assistance, but also with equipment, vehicles, etc. to make it possible to perform work in the provinces.

The *Programa Nacional de Promoção de Saúde* (National Programme of Health Promotion) started in 1979 as a result of the Alma Ata conference in 1978. It was a multisectoral programme, in the sense that it included all the other programmes of the National Directorate of Public Health, i.e. EPI, Maternal and Child Health, STDs (which from 1985 includes HIV/AIDS). The programme worked with the *Comissão Nacional de Saúde* (National Health Commission) which had been created in 1982 and was made up of representatives from relevant ministries and the mass organizations. The women's organization OMA, the youth in JMPLA, the *Brigadas de vigilância* ("Vigilance brigades"), the trade unions in UNTA were all obliged to participate and they all had different areas to work with. OMA was responsible for maternal and child health, while the youth organization took care of STDs and the so-called family education in schools and later also AIDS information. The Brigades were responsible for environmental hygiene and UNTA for occupational health. This was the model for working in the 1980's, i.e. before there were any national NGOs and other independent civil society groups working with health and social issues.

The programme had benefited from WHO support and some Angolan health staff had got the possibility to attend a Health Education course in Lomé. When the programme was later included in the Sida budget, one of the first actions was to send all Health Education staff from the provinces to Mozambique for training.

The programme had small sections in the provinces, and these all received equipment and material thanks to the Sida funds. Health Education was not a priority area for the government – and is still not – all the more the significant importance of the Sida support. All Health Education offices in the country got TV sets, generators, bicycles, motorbikes, copying machines, overhead projectors, flip-over pads and furniture. And the office in Luanda

was not forgotten... The present director, Dr. Filomena Wilson, however has this to say about the situation:

One must say that it wasn't the best period to make such big investments, because it was a time when there was nothing to buy in the country, and on top of that security was bad. Several cars were stolen, likewise office equipment, especially in Luanda. But Sida equipped us once again, so that we could function. Also a lot of the equipment that belonged to our programme was used by the Health directors. But what we see in the provinces today are still the same things that we got from Sida a long time ago.

(Personal communication, 2006)

An ex-Ministry staff alleges that the programme simply was sabotaged by one of the former ministers, who laid hands on all the equipment and distributed it according to his own preferences.

The programme had three Sida-recruited personnel, of different nationalities. Ms. Lene Blegvad Jakobsen worked with the Health Education programme during one year (1987–1988) and gives an interesting account of the development of the programme, but also of her impressions of the MoH:

Generally speaking, it is difficult to plan, organize and evaluate the performed work as a routine task more or less everywhere in the MoH, and communication is very limited at all levels. One explanation is the vertical management and command system, which characterizes the working methods everywhere you go. I think this is the most difficult aspect of our adjustment at the workplace and it can have a directly hampering effect when you want to introduce some change into your respective field of work. To try to change this vertical system into more collective/democratic work processes is very desirable, but will take years.

In the National Health Education Programme we have tried to establish regular weekly meetings, with varying results, made up of an agenda, written minutes, etc., to achieve better planning, performance and evaluation of our work and the internal communication. The frequent mistakes and misunderstandings would seem to help understanding the advantage of this work method.

We have also made a distribution of tasks, according to our different qualifications, i.e. administration, production and pedagogical tasks. But we do overlap each other when necessary.

(Blegvad Jakobsen, July 1988)

During this period, the programme was elaborating a methodology for supervision and evaluation of the activities at province level, and Ms. Jakobsen's report gives the impression of a quite dynamic environment. But the programme has problems to establish regular collaboration with the other prioritized PHC programmes, which is needed in order to produce posters, manuals, and audio-visual materials. And the National Directorate of Public Health has so many tasks that it cannot cope with all its responsibilities; this also affects Health Education negatively.

Lene Blegvad Jakobsen has an optimistic view of the future of the programme as such, since work methods are improving resulting in a gradual improvement in its capacity to fulfil its mission to strengthen the preventive side of the PHC system throughout the country. She is also impressed by the high work morale and the commitment of her colleagues, since she is well aware of the living conditions that were becoming tougher day by day, the low salaries and the high costs of living, etc., and on top of all the daily problems the fear of the threatening war. When looking at Health Education in a wider perspective, however, she is more pessimistic because the problems of the Angolan society are serious – and especially in Luanda, which at the time had an estimated population of 1.5 million inhabitants – and have direct bearing on the health situation in the entire country.

The present director shares this opinion. Health Education is a very complicated area:

It is one thing to transmit a message to people and, e.g., tell them to boil the water; but it is another thing to put such a message into practice. The big problem is the environmental hygiene and all social problems that are not being solved.

(Personal communication, 2006)

But Filomena Wilson concludes that the Sida contribution, after all, was very important for the development of the programme:

Without Sida's support nobody in this country would ever have heard of or talk about Health Education.

(Personal communication, 2006)

Endemic diseases

Malaria, TB/leprosy and trypanosomiasis were included in the Swedish health support programme in 1982 and phased out in 1993. The first budget was 16.5 MSEK, and was later increased to 34.5 MSEK and 41.5 before Sida decided to cease funding endemic diseases. The three programmes were originally under the *Direcção Nacional de Controle de Endemias* (National Directorate for Control of Endemic Diseases), but function today in other institutional settings.

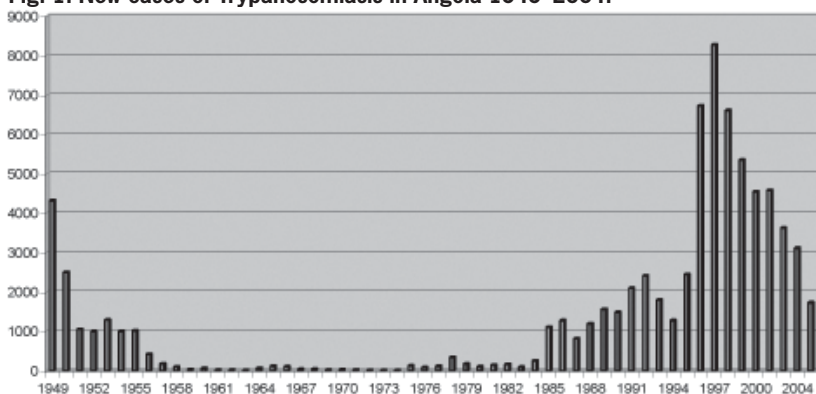
Sleeping sickness

The programme for diagnosis and treatment of trypanosomiasis was included in the first health agreement, as part of the malaria programme/endemic diseases. It functioned like a triangular cooperation between WHO, who supplied technical assistance, Sida who was supporting with a foreign currency contribution for import of vehicles, laboratory equipment and reagents for the testing in the areas where the prevalence of sleeping sickness was on the increase. The Angolan budget in Kwanzas, which was around USD 1 million/year, went to salaries, and other local costs.

African trypanosomiasis, is a serious tropical disease that is always fatal without treatment. The parasites are spread by tsetse flies, found only in Africa. The prevalence of trypanosomiasis has historically been highest in the North of the country, which is a region with rich agricultural production. Five provinces used to be affected, namely Zaire, Uíge, Bengo and Kuanza Norte, but today the disease has also spread to Malanje and Kuanza Sul. It might also exist in Kuando Kubango – the first Minister of Health belonging to UNITA (after 1992) reported that UNITA's health agents had detected cases there.

During the colonial era the Portuguese had an effective system for combating sleeping sickness, and the disease was practically eradicated at Independence. Only three cases were diagnosed in 1975. But soon after Independence, cases were reported from the North, partly due to the influx of people from Congo/Zaire. The prevalence rose to 20–30% in some areas. The following graph shows the development of the disease over time:

Fig. 1. New cases of Trypanosomiasis in Angola 1949–2004.



Source: Prof. Théophile Josenando, ICCT.

Dr. Rosário Pinto, a well-known trypanosomiasis specialist, continued the work after Independence with mobile teams that made sample testing of large numbers of people in the affected areas. The first Swedish adviser, Dr. Martin Björck, was involved in the work in from 1983 to 1985 from his position at the National Directorate for Public Health:

At the time the sleeping sickness programme had a plan where 1 million people in the affected areas in the North were supposed to be tested annually. The Swedish aid paid for the tests. When the plans were to be implemented it was obvious to the Angolan staff and to me that the capacity of the programme was limited and a realistic estimate suggested that 200,000 tests could be done. But the reagents had a limited shelf-life and would be wasted. I suggested that the Ministry should order for only 200,000 but that was complicated, since the plans had been approved. I then suggested a compromise: We stick to the plans but change the order. This was acceptable and the 1 million tests were delivered over a five year period. *(Personal communication, 2006)*

The most active period of the programme was 1982–1992. The Swedish support was substantial and the programme expanded and approximately 50% of the population at risk was reached in 1990. But when the war intensified again, activities were brought to a standstill. The programme lost all its vehicles, which were captured by UNITA, since the field work was taking place in areas controlled by UNITA. The Catholic church and some NGOs were allowed to enter into these areas, but not a government programme. The way to maintain some activities was to start training people from the church and the NGOs, since they had not got the know-how to treat trypanosomiasis patients. The programme also had some people left in the UNITA areas, and they were able to work together with the civil society organizations.

Sida support ceased in December 1993, but the programme resumed its activities again as soon as the security situation permitted. In recent years the results of scientific and technical research produced new tools and improved field control strategies. In 2006, the programme had eleven doctors and 85 beds in the Trypanosomiasis Centre in the Viana district in the Luanda province.

The tsetse fly exists in fourteen of the eighteen provinces of the country, which means that theoretically 1/3 of the population live in risk zones. The programme has been able to accelerate testing during the last few years and the number of confirmed cases has decreased since the end of the 1990's. The programme is still working in a vertical way, since it would require specialized competence at Health Centres to treat patients, although new drugs have made treatment much shorter than before and, thus, less complicated. Patients have to be medically checked during at least two years, and it is not realistic to mix them at crowded Health Centres with patients with all the most frequent infectious diseases. Only with few cases of trypanosomiasis can one start preparing for "horizontalization".

Combating sleeping sickness

Of the 36 countries where trypanosomiasis is endemic, 22 are actively involved in the WHO programme to combat the disease. The most effective approach for controlling sleeping sickness has three parts:

1. Mobile medical surveillance of the population at risk by specialized staff using the most effective diagnostic tools (serology and parasitology) available. Patients are sent to specific referral centres for determination of the stage of the disease and treatment, and for post-therapeutic follow-up
2. Fixed post medical surveillance delivered at Dispensaries, Health Centres or Hospitals where blood samples are taken and analysed at reference centres. All patients or suspected cases are sent to special centres for confirmation of diagnosis, determination of the stage of the disease and treatment, and for post-therapeutic follow-up
3. Vector control using screens and traps: simple, cheap and ecologically acceptable methods.

Source: WHO

The programme is today led by Professor Théophile Josenando, who started working with it in 1982, and has accompanied the Sida support all the way:

The Swedish support really made a difference when we could do our work, but when the war broke out again it was naturally of no help. But now, yes, now it could make a difference again... But I think the Swedes stopped the support because of the bad management of resources in the Ministry and not because they wanted to.

Since 2004 we are an Institute with autonomy²⁹, which makes it possible for us to cooperate with other countries. The Institute has no political “cover”, only technical. We get our budget from the Ministry of Finance and the system is very safe, since there is control by the Audit Court. We have a good staff; the only problem is that the Ministry of Finance doesn’t allocate any funds to us as it is supposed to do. But we have set our goals: Eliminate the disease, horizontalize treatment and eventually eradicate trypanosomiasis in Angola.

(Personal communication, 2006)

Tuberculosis and Leprosy

The TB/leprosy programme had WHO support during a couple of years before Sida started funding it. The programme had an annual budget of approximately 3.0 MSEK out of the total budget for endemic diseases. An evaluation was carried out by consultants to Sida in 1988, and one of their

²⁹ Instituto de Combate e Controlo das Tripanossomíases ICCT (Institute for Combat and Control of Trypanosomiasis).

recommendations was to make annual evaluations and this was also done until the Swedish support terminated in December 1993.

The director of the programme, Dr. Joseph Nsuka, is today Provincial coordinator of endemic diseases (except HIV/AIDS and trypanosomiasis) in Luanda and director of the TB/Leprosy Dispensary in Luanda.

TB is a major public health problem in Angola and the number of reported TB cases has increased from 11,500 in 1999 to more than 31,000 in 2004. Coverage with Directly Observed Therapy (DOTS) is increasing, but drop-out rates remain high, probably as a result of the post-conflict setting.

In post-war Angola, a substantial proportion of the population is vulnerable to TB. A large part of the population was displaced during the war and many of the country's health facilities were totally destroyed. Of the remaining Health Units, only 20% have laboratory facilities, and only a small percentage of the population has access to these facilities. In addition, TB drugs are still in irregular supply, and Health Centres often experience stock-outs. (TB drugs are not included in the essential drugs kits.)

In Luanda approximately 10,000 new TB cases were diagnosed in 2006. The fact that more and more TB cases are reported depends on the increasing medical checks and detection of new cases. These are treated with the DOTS therapy, and TB drugs are free of charge. When dispensary staff hears about the sale of drugs, they always try to find out and take counteractive measures.

Regarding Sida's withdrawal in 1993, Dr. Nsuka says that it was a pity that Sida suspended the support, because "*the MoH couldn't walk alone...*". But today several donors and agencies are working with the MoH with TB prevention and control. The Global Fund to Fight AIDS, Tuberculosis and Malaria and WHO are the major multilateral partners. Many NGOs are also involved in supporting TB programs and the Luanda Dispensary is supported by the Italian Collegio Universitario Aspiranti Medici Missionari (CUAMM). The World Bank is in the second year of a five-year agreement with the government to finance a \$20 million project, and the Global Fund is in the second year of an \$11 million program, both supporting Angola's TB and HIV/AIDS control program.

Through CUAMM, via the MoH, the programme in Luanda has received support for training and supervision as well as drugs since year 2000. The programme works with Health Education lectures at the Health Centres, and theatre groups of young people help spreading the message in the communities.

Also leprosy examination and treatment receive support, which is not institutional but more small-scale and scattered, since it mainly comes from churches and NGOs. The disease exists all over the country, but the prevalence is supposed to be relatively low, less than 1 case/100,000. But it is difficult to reach out and work in some of the biggest provinces where the disease exists,

e.g. in Uíge in the North. In Luanda health staff work in the communities, with active detection of cases – 217 new cases appeared in 2005. Work is generally easier in Luanda, since the sick do not hide when the visitors come, and it is also possible to have staff from the programme working permanently at the Health Centres.

The Angolan government has adhered to the WHO programme to eradicate leprosy, which means that the national programme has to be more aggressive than before.

Malaria

Malaria is one of the most serious health problems in Angola and is estimated to represent 50% of the curative demand in the country. It is endemic all over Angola, with the highest transmission in the Northern part of the country. The malaria programme was consuming the major part of the Sida budget allocated for endemic diseases.

Malaria – a disease with tragic consequences

In Angola, malaria is by far the largest cause of mortality and morbidity among children. In 2000, the MoH reported that over 75% of all illnesses and deaths in national health services were related to malaria. Malaria also has extensive effects on economic productivity and households' income. The disease is the first cause of absenteeism among Angolans at school and at work. According to the National Malaria Control Programme, every Angolan typically experiences 3 to 5 malaria episodes per year.

Source: MICS, 2005

When the Sida support started, there was no Angolan malaria specialist in the country and Dr. Fernanda Dias, who was then the programme director, got a grant for specialist training in Portugal. When she came back the programme gained impetus, but shortly after her return she was suddenly removed by the Minister of Health. Nevertheless, she has never left the malaria field and has been teaching at the Faculty of Medicine and is today Head of Department of infectious diseases at one of the university hospitals in Luanda. Dr. Fernanda Dias tells about the early times with Sida:

When we got the support from Sida it was necessary to mobilize the dynamic people in the endemic diseases programmes to be able to perform. The Swedish support was very important during this stage. Sida was mainly responsible for equipment and drugs, while WHO supported training of the programme staff. The most important result was the reference laboratory here in Luanda, which was the first in the country, plus the training we could do with Sida budget.

We identified the problems and the necessary resources, and then Sida allocated the resources. And there was always more Swedish crowns coming! It was tough in the beginning, because the programme officer at Sida, Ms. Kerstin Fransson, was supervising everything and had a very strict control. When there was a quarterly meeting coming up we were grudging – God we have to sit with that lady again, we have to have all papers and figures in order – but when looking back I realize that we learnt a lot through those exercises. None of us had any management experiences, so it was useful after all. And after a while, we understood some of Sida's principles so we didn't ask for more vehicles, but invested in training instead. Today I work with a lab technician who got his professional training twenty years ago. I must say that I consider myself a daughter of the Swedes.

(Personal communication, 2006)

According to data from the MoH for 2000, malaria was the absolutely largest killer, 76%, among children, followed by acute respiratory infections and diarrhoeal diseases (both 7%). The MICS 2005 present data about malaria treatment indicating that 61% of <5 children had been ill with fever in the last two weeks and had received anti-malarial drugs. But only 2% of the <5 children were sleeping under a bed net impregnated with insecticide. Occurrence of fever is about the same among children surveyed, with little variations between socio-economic groups, areas of residence and sex, indicating that the fever indicating malaria affects children from all segments of the Angolan population. The MICS and other studies show that Chloroquine is still the most accessible anti-malarial drug, which is a problem since in Angola 50% of malaria cases are resistant to Chloroquine.

If the occurrence of fever does not distinguish among socio-economic groups, the use of bed nets does. Children from the most vulnerable households are three times less likely to use mosquito nets (treated or untreated) than children from better-off households. The MICS shows that economic constraints remain an important factor as to whether a household will appropriately protect itself against malaria or not. Within the framework of the Roll Back Malaria Initiative, the National Malaria Control Programme launched in 1998 a large project to promote the use of insecticide treated mosquito nets with the support of UNICEF. At the beginning of 2003, the project was operating in fourteen provincial capitals where 500,000 nets were distributed at very low, subsidized price. 47 Insecticide Treatment Units for the impregnation of nets were also established. Whether this will help the poorest to protect their young children is not yet clear.

Dr. Ana Vaz is the Head of Department for Hygiene, Epidemiology, Environmental health and EPI of the MoH. She was the director of the Malaria programme during 1991. She compares the situation fifteen years ago with today's situation:

During the war we had of course a lot of problems, but it was easier to mobilize people to work – ‘*those who don’t collaborate are against us*’. The programme had all necessary components, had full control over drugs and training, etc. Today it’s different; the reference laboratory has been taken over by the *Instituto Nacional de Saúde*³⁰.

But I must say that I’m against vertical programmes. I believe nurses at Health units must know about all the diseases, not only malaria. Here we work with so-called ‘integrated vigilance’, but it’s very complicated to implement because people are so used to working in a vertical way. And with new institutes popping up it will be even harder. *(Personal communication)*

HIV/AIDS

In Angola the first HIV case was detected already in 1985, and the collaboration with Sida started one year later, in fact before HIV/AIDS was formally included in the agreements and budgets. The receiving institution has always been the *Centro Nacional de Sangue* (National Blood Centre). This blood laboratory did not have enough resources to start testing blood for transfusions, after HIV had been detected. Big volumes of safe blood are needed for the very frequent blood transfusions that take place in Luanda. Sida started to buy reagents for the CNS in 1986, and then the cooperation developed step by step.

The CNS came to work in partnership with the Swedish Bacteriological Laboratory (today Swedish Institute for Infectious Disease Control), which started the collaboration with an appraisal of the existing resources and capacities. Several short-term consultants of different specialities came to make preparatory studies. And Sida wanted to include the CNS, since the laboratory was working well under good conditions.

The laboratory functioned as a reference laboratory to confirm blood tests made in the provinces or at the Luanda hospitals. The CNS laboratory started to make ELISA and Western Blot tests, which are too expensive and sophisticated for other laboratories. Especially Western Blot was very expensive also for the central laboratory, but it was possible to make an agreement with SBL to take the samples to Sweden to make the confirmation tests in the cases where CNS’s test results differed.

This developed into a small and rather technical cooperation with technical assistance from SBL and the practical components like the testing. Dr. Luzia Fernandes has been directing the CNS since the beginning, and she made a study trip to SBL together with a small group of laboratory technicians at the

³⁰ National Institute of Health.

very onset of the collaboration. After twenty years, two of these technicians are still working at the CNS.

Presently, there are thirteen “Advanced Posts” in Luanda and posts in all provinces. They can make rapid tests of HIV, Hepatitis B, and syphilis, and confirmation tests are made by CNS when needed. Doctors from the CNS are responsible for the supervision of the posts.

The main reasons for blood transfusion are:

- Malaria in children
- Sickle cell anaemia
- Haemorrhage during child birth

The malaria incidence has peaks, and hospitals in Luanda can make 100 transfusions per day during the rainy season. Children receive 60% of all transfusions.

Sida facilitated the contact between CNS and the WHO, which has also given valuable support through the years. Sida has funded the CNS laboratory and the SBL collaboration, while WHO has supplied the rest of the country with reagents. Sida phased out its support in 1999, but even after that the CNS has had some small support via the CAOL and CAPEL programmes in Luanda, since safe blood is essential for the MCH area. Up to year 2000 the CNS was struggling with its budget, but after that it started to get its budget allocated directly from the Ministry of Finance, which makes it possible to buy reagents, although the CNS cannot supply the provinces. Like some of the other institutions involved in the Angolan-Swedish cooperation, CNS, has become an autonomous national institution. This implies a separate budget from the Ministry of Finance and a relatively sustainable situation for the future.

Maternal and child health

The emphasis on reproductive health by the end of the 1980's not only led to the reorganization of the obstetric services, but also to strengthening of antenatal care and family planning, and later to the building up of a modern midwife course. After the positive tendencies of the decentralization of deliveries to Health Centres, the next step was to try the same model for paediatric care. One could say that Sida and Angola succeeded in adopting a human rights approach to the reproductive problem – after so many years of negligence women's and children's right to survival and health rose to the surface. The problems are huge and complex, and will need more time and even greater commitment from the Angolan government and all involved structures to produce in-depth results.

Maternal health

After the analysis of the maternal health situation and the prevailing inhuman conditions of the big maternity hospitals in Luanda, the MoH and the provincial health authorities agreed with Sida to start implementing the decentralized system with obstetric services at some of the Health Centres in Greater Luanda. The coordinating body CAOL which, besides the directors of the maternity hospitals, included important stakeholders such as the Angolan women's organization OMA, Sida, UNFPA, UNICEF and MSF, had developed a strategy but it took time before there were any results. After some time, OMA had to react and published an article in the daily newspaper *Jornal de Angola*. This article had effect, and the bureaucratic blockages were finally removed.

When CAOL's work started, Luanda had two specialized maternity hospitals; Lucrécia Paím, which is a national hospital, and Augusto N'Gangula, which was originally a provincial hospital, but has recently been upgraded to a general hospital³¹. These hospitals are from the colonial times, and just before Independence Luanda had only 8,000 institutional deliveries per year (1973), to be compared to the situation in 1989, with 32,000 deliveries, 1999 with 59,753 and 2005 with 90,160. Before the decentralization, the majority of the institutional deliveries – normal as well as complicated – took place at Lucrécia Paím and Augusto N'Gangula,³² and the hygienic and working conditions gradually became totally unacceptable. 100 deliveries per day at each hospital was, more or less, a normal figure. In the new system Lucrécia Paím and Augusto N'Gangula are supposed to serve as 1st level health units, after District Hospitals and Health Centres.

During the CAOL period and with the support of Swedish advisers – long-term technical assistance through InDevelop and short-term consultants – the conditions of the hospitals have improved a lot, and special measures have been introduced for reducing maternal mortality. It is, though, important to mention that maternal health also has received support from some international NGOs, such as Médecins Sans Frontières and Médicos Mundi, and from several bilateral government agencies besides Swedish Sida.

Professor Staffan Bergström initiated a series of seminars for obstetricians and midwives in 1993, which in reality turned out to be a kind of maternal mortality audits. Professor Bergström understood that there was a need of more knowledge and experiences from other countries – evidence-based obstetrics – among those who were working with obstetrics and maternal health care in general. The first seminar was held for doctors and midwives in separate groups, because of the classical barrier between these professions. But the Swedish lecturers wanted to break down the barrier, and the following

³¹ A general hospital gets its budget allocation directly from the Ministry of Finance.

³² A few deliveries took place at Kilamba Kiaxi District Hospital until it was closed for rebuilding. In addition to the aforementioned public hospitals there are several private hospitals and smaller clinics in Luanda, but there are no available data regarding the number of deliveries taking place there, and consequently not of the quality of care.

seminars took place with big mixed groups. Angolan midwives were invited to lecture, which was also something uncommon, but eventually well accepted by both categories. After ten visits in Luanda, the “Swedish” seminars came eventually to an end, but are followed by *Jornadas Obstétricas* (“Obstetric days”), organized by Lucrécia Paím Hospital with a certain regularity.³³

Maternal mortality, one of the highest in the world

Maternity wards, where are they?

Excerpts from *Jornal de Angola*, April 1991

A pregnant woman comes walking the long way from home to the maternity hospital. She is very tired, but she knows that at the hospital she will at least, in principle, get adequate help. In the few Health Centres that are functioning in the outskirts of town the technical conditions are often lacking, as well as the drugs. In the hospital, after having been attended, this woman is advised to buy the drugs at the market and come back for another antenatal care visit after a month. She is too tired to go and buy the drugs. And since she does not take them she even more tired, and then she does not even return to the hospital. If her delivery is without problems, very good, but if there are any complications she might even die because of lack of adequate treatment. In the neighbourhood where she lives, there is no Health Centre with a maternity ward, and the same goes for the other districts.

In Luanda 80,000 women gave birth to a child in 1990. 35,000 of them had their child at a maternity hospital, i.e. 45%. 1–3% had the child with the help of an upgraded traditional midwife; over 50% had inadequate assistance. Most women are assisted by family members or neighbours with little experience.

The maternal mortality rate in Angola is one of the highest in the world. More than half of the maternal deaths could be avoided with a better obstetric treatment.

There is an “Operational Plan for Maternal Health in Luanda 1991–1995”³³ whose main objective is to reduce the morbidity of pregnant women and the mortality of women giving birth in the Luanda province.

...

But if so, what is going on in Luanda? The Neves Bendinha Centre was repaired and seems to work very well. But we cannot help observing that in the initial plan there was a maternity ward. This was never built. Why? The Américo Boavida Hospital is being restored, but no maternity wards are planned. Why? In Viana there was an MCH Centre working. Two cooperantes needed a house to stay in. So, the MCH Centre was transformed into a residence. And in the Health Centre in Viana, there is equally no maternity ward.

...

Recently three big pavilions were built because of the cholera epidemic. They were ready in six months. This shows that it is possible to build when there is a will.

The funds exist if one looks for them. It is a matter of priority.

It is obvious that in a country with such precarious hygienic conditions we must be prepared for a possible outbreak of epidemics like cholera. But if we calculate a little, more people die while giving birth than from cholera. From 1989 until April 1991 326 persons died from cholera. In only one year, in 1990, 332 women died in the two maternity hospitals in Luanda. Because the hygienic conditions, and others, while giving birth are, unfortunately super-precarious. Why not also take serious measures to prevent the dramatic maternal mortality situation? Because it is a “women’s issue”? That is what it looks like.

³³ The Operational Plan was developed by a team of Angolan and expatriate specialists and finally compiled by the PHC adviser, Dr Britta Nordström. The article in *Jornal de Angola* was written by the Swedish journalist Birgitta Lagerström who was working as an information officer at OMA at the time.

One of the important reforms to help bring down the institutional mortality is the eclampsia units that have been established at the Luanda hospitals and at the two 2nd level district referral hospitals (Cajueiros and Kilamba Kiaxi). Norms for treatment of eclampsia were developed in the 1990's by one of the InDevelop advisers, and the results are very positive, although there is not a stable decrease of deaths. The work of attacking maternal mortality by pathology is ongoing, and Augusto N'Gangula Hospital has succeeded to reduce malaria related mortality from 28% in 2001, to 13% in 2004.

The intrahospital Maternal Mortality Ratio (MMRi) varies a lot, depending on the source, and it must be noted that there is no reliable information about extra-institutional maternal deaths deliveries, which are the most frequent in the country. Some examples of data on maternal deaths illustrate the spectrum:

Table 8. Estimated maternal mortality in Angola, different sources.

No. Deaths/100,000 live births	Source
1,300/100,000	National Institute of Statistics, Luanda province, 1994
>1,400/100,000	International Medical Corps, Luena, Moxico, 1994
600–900/100,000	MoH, national level, 1995
703/100,000	UNICEF Angola, Luanda province, 1995
1,500/100,000	WHO/UNICEF, national level,1996
1,500/100,000	MoH, national level, 2001

CAOL gives some figures in the last annual report (2005/06) to Sida, showing the development from 1999 to 2005:

Table 9. Maternal/reproductive health in the Luanda province, development 1999–2005

	1999	2005
Institutional deliveries	59,753	90,610
No. of maternal deaths	834	401
Antenatal care consultations	345,403	524,365
Family planning consultations	113,034	167,896

Source: CAOL

Information from Augusto N'Gangula Hospital shows a considerable decrease of maternal mortality. The Hospital has approximately 15,000 deliveries per year since 2000. The maternal mortality in 2001 was calculated at 1,097/100,000 and had decreased to 526/100,000 in 2004.

The number of Health Centres with maternity wards has been on a steady increase, from 11 in 2001 to 24 in 2006. (It should be observed that only half of the maternity wards have been created within the Sida supported pro-

gramme. Other agencies and NGO's are also supporting the Provincial Health Directorate to develop and maintain the decentralized system.) According to CAOL's statistics for 2005, 62% of the institutional deliveries took place at Health Centres at district level. The statistics regarding institutional deliveries should, however, be viewed in the light of the increasing population in Luanda. The maternity hospitals are still very crowded, while more and more deliveries take place in the periphery.

A problem that seems to be difficult to solve is the referral system between the different levels of the system. Risk pregnancies should be referred from a Health Centre to one of the district hospitals, or to the maternity hospitals in the city. A functioning transport system is thus needed, but the existing system is not reliable enough. The radio system is no longer in use since everybody has a cell phone, although radio is safer since ambulances can be reached directly in an emergency situation. From the hospitals, women should be referred back to a Health Centre if they are judged to have a normal delivery. (This should apply when a woman goes to the maternity hospital as a preference, and not as a referred patient) This contra-referral usually does not happen simply since gloves and syringes are (illegally) sold by the hospital staff, which makes women refuse leaving after already having spent money to be received at the Hospital.

Another problem that affects pregnant women – and other persons seeking care – is the seemingly generalized phenomenon with the illegal fees, *gasosas*, practiced at Health Centres and Hospitals. This prevents the poor pregnant women from attending antenatal medical check-ups, and subsequently, from seeking professional care at childbirth. The *gasosas* are no secret, all technically and politically responsible leaders are well informed about it, and the different rates charged are even brought up and compared during workshops/seminars for Luanda health staff. Rates vary and nobody knows exactly whether the money goes directly into the pockets of nurses and midwives or if it is used to support the meagre budget of the institution. The understanding is, though, that the money goes to the individual health worker, for whom *gasosas* mean an extra salary or more.

Some Health Centres in Luanda advertise on the door that childbirth costs 500 Kz, while others practice a more concealed system. Hospitals and Health Centres charge for blood tests and other, more complex, tests. Malaria tests should be free of charge for everybody, but even so people sometimes have to pay. (The “open” and advertised fees are usually called *contribuições*, i.e. contributions from the public/patients, and are today an important financial source for poor Health Centres and small Hospitals – when they are managed in a controlled way.)

These anarchical fees – the euphemism often used for an illegal but evidently tacitly accepted system – is one of the most important obstacles to promote safer childbirth in Luanda. A woman in labour usually needs trans-

port to the Health Centre or Hospital and this cost, together with *gasosas*, and maybe even the need to pay for medical consumables and drugs, create an insurmountable obstacle for any poor woman to seek help at childbirth. Especially the youngest women, who have no income of their own and at the same time are the most vulnerable, run a big risk in this system. The idea of paying for care that should be free has become so deeply rooted that patients desist from seeking health care if they do not have the money.

In spite of the many problems, and although statistics remain unreliable in Angola, we are certain that the data from Luanda give a correct picture of the positive tendency of the decentralization efforts. These results are rewarding for all those who are committed to improving maternal health services and save mothers and their children, and it is also rewarding for those who have supported this Luanda initiative. It is often stated that the Luanda model will be copied by other provinces, but so far this has not happened, since its implementation requires qualified staff – mainly midwives – and other resources to improve the infrastructure and equipment at the hospitals and create maternity wards at the Health Centres.

Course for specialized midwives

The course for nurses to become specialized midwives can be seen as a result of the analysis and efforts developed within CAOL. Midwives were working at the big hospital, but most of them had not the right background and did not meet the standard required for the profession.

As part of the training programme funded by Sida, some nurses/midwives got scholarships in the 1990's to study in Brazil, and a couple of them are now responsible for the midwifery course.

The course has a long story; it took time to prepare since it involved developing a new curriculum. Several Swedish midwives were involved in the process, and one Swedish nurse tutor worked together with the Angolan tutors during the initial stage of the first course, which could finally take off in 1998. There was a consensus between the Human Resource Department of the MoH, the leaders of the course and Sida that quality should carry more weight than quantity, since the whole idea behind the new course was to create a new female profession that could gain respect for its technical level and ethical virtues. 92 midwives have graduated up to 2006. The same course will be multiplied in Malanje and Lubango, which hopefully will contribute to maternal health care in several provinces, since students come from many corners of Angola to study it.

A few male nurses applied for the course, but they lost interest. Experience shows that women usually do not accept assistance from male nurses at deliveries – the maternity ward in Malanje was deserted, since there were only male nurses to assist women at childbirth. After some of the midwives from the first course went out to talk to women in the communities, it became

clear that they boycotted the maternity ward because of the male presence (the men had to be transferred to the family planning services).

The course can only cope with 25 students per year. Among entrance criteria, the most important is to have experience as a reproductive health nurse. Student selection sifting is thorough. It includes interviews, etc. and much time is given to personality assessment. Several of the most competent obstetricians lecture at the course, and some of them closely collaborate reviewing the curriculum or assist making other course adjustments or evaluations.

Some years back the course was recognized by the MoH, and integrated in the ETPSL (Technical Vocational Health School). The entire salary system for the health sector is under redefinition, and some legislation has been approved but not yet implemented, which means that the salary level of the specialized midwives has not yet been definitively fixed.

Child health

CAPEL (*Coordenação de Atendimento Pediátrico de Luanda*/Coordination of paediatric treatment in Luanda) was created in the mid-1990's as a coordinating body for the child health sub-sector in the Luanda Province. Also CAPEL got both financial support and technical assistance – less than CAOL, though – to implement training of staff, and to introduce general improvements of health services at all levels.

The objectives of the child health project are the reduction of infant and child mortality, improved child health, and, also, improved child health care. Through the project a series of paediatric units have been established at Health Centres (which also have delivery rooms) so that parents can reach medical services closer to home. These paediatric wards shall function as emergency wards with 24-hour service. The Paediatric Hospital David Bernardino in Luanda has, equally, got financial support and technical assistance, and in the beginning 2006 a new paediatric clinic was inaugurated at Augusto N'Gangula Hospital financed by the Angolan Government.

From CAPEL's data one can observe a clear tendency that Health Centres are playing a role in alleviating the pressure on the Paediatric Hospital. But like in the case of the maternity hospitals, the population of the “asphalt city” is big enough to keep the hospital crowded, which is still the case. Like for maternal health, there is no functioning referral system, and there seems to be deeply rooted habits to take a sick child directly to the hospital. This situation will probably remain until a referral system is created that can be trusted by the people.

CAPEL has mainly been working with the implementation of the IMCI programme (*Integrated Management of Childhood Illness/Assistência Integrada às Doenças da Infância*) which has implied staff training and supervision of the new paediatric wards. The IMCI programme is a welcome horizontal ap-

proach, in the otherwise rather verticalized system, since it is supposed to amalgamate all different child health programmes into one.

Immunization has become a regular activity within the child health units (and hospitals) aiming at reducing illness and death in preventable diseases. One important aspect is to minimize the gap between BCG immunization, which has good coverage, and the DTP which has low coverage. The special vaccination rooms that exist at Health Centres – with a special nurse who is usually the only staff dealing with immunization – are currently being eliminated, and children are immunized when they, for example, are brought for weight checks.

CAPEL has also been trying to develop from a kind of vertical project to integration into the provincial health structures. The former CAPEL coordinator Dr. Isilda Neves is Director of Public Health at the Provincial Health Directorate. After the phasing-out of Sida's support in March 2006, CAPEL no longer exists and has been integrated in the MCH programme under the PHC section, which is headed by the former coordinator of CAOL, Dr. Isabel Massocolo.

The Paediatric Hospital David Bernardino has mainly got support to establish an emergency laboratory for testing for meningitis, malaria, etc. Both Swedish and Portuguese consultants have been working with training of the laboratory technicians at the emergency as well as microbiology laboratory.

The Director of the Hospital, Dr. Luís Bernardino, explains that the demand for child health care is extremely great, which explains the constant stream of patients to the Hospital. There is a need for more paediatric emergency wards, and the Américo Boavida Hospital ought to establish such a service, but there is no political will to introduce changes in the Luanda system. Although CAPEL has not succeeded in spreading over the whole city, it has achieved some positive results. About the Swedish cooperation Dr. Bernardino says:

The Swedish support has improved quality, and our Hospital has now got the best laboratory in Luanda. I think Sweden has had the right approach. Personally, I'm very much in favour of North/South exchange and our collaboration with the Swedish paediatricians has been very valuable. I think, though, that we should need to continue with other areas, because we have a quite good level at our Hospital now.

Our cooperation has been exemplary, in my view. The Swedes were able to integrate into the machinery. They are very different from the NGO's, for example, the Swedes have really made big efforts to work within our institutions. But I'm afraid they ended up very disappointed. *(Personal communication, 2006)*

CAPEL, as a coordination structure, did exist for too short a time to show more solid results. But hopefully it has laid the foundations for a rationally organized integrated child health structure which, together with the reproductive health, should have the highest priority in the near future.

Training of nurses

The big investment in training of nurses through technical assistance to *Instituto Médio de Saúde de Luanda* started during 1986, with the arrival of a group of nurse tutors and pedagogical experts. It seems like this programme should have needed better preparation from the Swedish side, since the prevailing conditions at the Institute were not the best to start developing and improving the courses for medium level nurses. And the main question mark is why Sida at all agreed to support medium level nurse training, when there was evidence that the majority of the students from the Institute had no interest in strengthen the PHC as trained nurses, but were using the middle level course for other professional or educational career purposes.

One problem that influenced the initial work of the Swedish tutors, was the absence of professional Angolan nurse tutors – the teachers were *monitoras*, i.e. former students who had never worked as nurses themselves and lacked practical experience from the health sector and thus had difficulties carrying out their work. The situation improved gradually, since some of the *monitoras* took their tasks seriously and improved their teaching, and the Swedish tutors became more acquainted with their tasks after some time.

Some of the Swedish tutors had job descriptions that were totally unrealistic, since the Institute's organization was floating along with a new and inexperienced director without pedagogical background, and the Swedish tutors did their best to understand where they fitted in. But in spite of the initial difficulties, Ms. Krestina Ekström), stayed for five years at the Institute. In her final report to Sida she describes the despair she felt in the beginning:

When I started there was no exact information about the number of students. The teachers were waiting for their curriculum schedule despite the fact that several months of the school year had already passed. Most documents had been thrown into a wardrobe. The director of studies was studying medicine full time and worked only 2 hours/week. There I was sitting alone “sorting” papers and answering “tomorrow” to all questions, because I neither spoke nor understood Portuguese and I didn't know if the people who talked to me were students or teachers.
(Ekström, May 1991)

During these five years, there were nine different directors of studies, which made planning and organization more complicated than necessary. The Institute had too many students than it could handle, and students were admit-

ted capriciously. But the biggest obstacle in the work was to be an expatriate adviser. Krestina Ekström felt a generalized suspiciousness against foreigners, regarding professional qualifications as well as contract benefits. She lists some other problems she reacted against:

- 26% of the new student had been admitted on false documents
- For the over 700 students there was only work experience placement for 1/3 of them, which is very negative in vocational training
- 1/3 of the teachers paid on hourly basis stopped teaching during the school year and students miss part of the courses of mathematics, Portuguese and other core subjects
- 70% of the administrative staff is studying half time. This is also the case of the librarians, which means that the library is mostly closed

Dr. Lino Silili has a long background at the *Instituto Médio*, where he started as *monitor* and later became the coordinator of the nursing course in the 1980's. He belonged to the group that went to Brazil to study, and is the present Director of the new vocational school *Escola Técnica Profissional de Saúde de Luanda-ETPSL* (Luanda Technical Vocational Health School). He explains that the Department of Human Resources of the MoH has been working since 1997 with a comprehensive reform, a Human Resources Development Plan, which includes creation of new careers, promotional system, upgrading of staff, etc. The *técnicos básicos* will disappear, and the nursing careers will in the future be auxiliary, professional and academic nurses. But it has not been easy to implement the reform, it has taken time.

The old Institute closed admissions in 1997 and was closed 2002–2004. The new vocational school will have the following courses:

1. Initial course
2. Specialized course³⁴ – theatre nurse, intensive care nurse, and anaesthetics nurse
3. Upgrading course

These new courses will lead to higher salaries, according to the new system.

Dr. Lino Silili has collaborated with all the Swedish tutors. He admits some of the negative aspects of the Institute, like the disorganized admission of students, and the lack of commitment among students who needed the medium course to be able to study at the university. But he has seen the impact of the Sida support, and he even benefited from it as a student at the Institute. In his view, the impact was quite positive since the Sida support contributed to improving the organization of the Institute as such:

³⁴ The midwife course belongs to the specialized courses.

We succeeded with teaching the entire course curriculum, and we were able to work with Public Health at community level because Sida gave us vehicles. We went to Bengo, for example, and worked with epidemiology, environmental hygiene, etc. We went out to inform and give health education, or we could build latrines, work with immunization, family planning and reproductive health.

I gained good experience working with the Swedes. But they were controlling everything – the other courses could not use any of our material, because Sida only supported nursing. This of course created some strained feelings in the Institute.

(Personal communication, 2006)

The support to the Institute and further nurse training (with the exception of the midwife course) terminated in 1992. The conditions for those who went to Brazil with Sida grants was to return and to be teachers at the different medium Institutes, which also happened, eventually. About all the students at the Institute there is no information – did they go on studying medicine, or did they end up in other professions?

Cooperantes in Angola

The Technical Assistance was an important component of the Health Support during more than twenty years. Approximately 45 persons have been working in Angola as coordinators/ administrators, advisers or tutors at the *Instituto Médio*. During a couple of years in the mid 1980's the Technical Assistance absorbed 25–30% of the total Sida budget. Some of the Swedish personnel have related their professional experiences above, but there are also other aspects of the *cooperante* life.

Critical voices about Sida

In the end-of contract reports, many of the Swedish TA personnel voiced their criticism against Sida. They often described rather difficult working conditions, especially immediately after arriving in Luanda, and felt at a loss because the Swedish Embassy was not interested in having a dialogue. Swedish development workers are supposed to identify themselves as Angolan civil servants, something they accept in theory, but most of them do not understand how the intricate Angolan bureaucracy works and how to tackle problems. They build up a lot of frustration, since they feel they cannot use their time in an efficient way, since work methods are very far from the Swedish way of doing things.

The first PHC adviser, Dr. Martin Björck worked at the National Directorate of Public Health. There was no beaten track, he had to find his own way, but felt well integrated with his colleagues at the MoH. But he was not always happy with Sida:

I often felt that the Sida bureaucracy was more difficult to deal with. We were left to cope with the situation. There were no medically trained personnel at the Sida office, and it was initially difficult to get support and feedback from the Sida office. This however improved during my contract period with an appointed programme officer for health at the Embassy.

(Personal communication, 2006)

In those days, when Sida employed experts/advisers for technical assistance, there was a tacit policy to let these employees solve their own problems at the workplace, and they were not supposed to discuss internal Angolan problems with Sida. The official forum was quarterly meetings, where information could be exchanged. As a consequence, many of the quite qualified professional people employed by Sida felt excluded, since they were not welcome to discuss improvement of their respective programme or to get support to discuss their own job descriptions (that were sometimes established years ago and no longer in tune with the current situation). One of the advisers refers in his report how he was informed by Sida that his role was not to give advice to Sida, but to the Angolan party.

There was also disappointment among some of the Swedes, for example, at the *Instituto Médio*, who felt that their knowledge about the Angolan education system, etc. was never used by Sida, while Sida listened to all the short term consultants who often presented rather superficial recommendations.

It is also evident that the level of adaptation to Angolan living and working conditions varied a lot. Some people complained loudly about the Portuguese language, and meant that Sida should invest in recurrent language training in Luanda, while others had a more relaxed attitude to Portuguese grammar...

Living and working in Luanda

When the first advisers arrived they lived in flats in town. Dr. Martin Björck had been active in the Africa Groups and came to Angola as a solidarity worker:

I wanted to work in Angola and felt a strong commitment and loyalty with the Angolan struggle. There was a strong sense of working together with the Angolans and no signs of corruption. We had a strong solidarity with the Angolans and felt that we were accepted. Our living and working conditions were similar to

the Angolans. We lived in an apartment with no water and seldom electricity. We did our shopping using ration coupons at the local cooperative.

(Personal communication, 2006)

In the 1980's, the *Campo sueco* (Swedish camp) was built in the *Miramar* area and later on Swedish housing expanded with an apartment block in the *Maianga* district in the central part of Luanda. Most of the Swedish personnel came to live in the *Campo sueco*, especially families with children. There are many comments about the high standard of the houses, and the fact that there was always water and electricity at the camp. But some people felt they were living on an island, far from the Angolan reality, which to a certain extent made them alienated from the daily life of ordinary people. Some said they only stayed at the camp because of their children, who had their playmates there. One of those who refused to live in the Swedish environment was the coordinator working in the Ministry, and later at InDevelop, who spent more than ten years altogether in Angola. She lived in an ordinary Angolan flat for several years, and says that it was the best of her Angolan periods. In that way she came to know people and to learn a lot about Angolan society and political life, which made her better understand what happened around her in the workplace and the motives behind decisions, etc.

Part 4: Analysis of Swedish-Angolan cooperation

Disbursement before development

During the 1970's and 1980's Sida had the right to transfer appropriations from previous fiscal years to the next, which could lead to huge accumulated balances³⁵. Yet, although formally acceptable, this was always inconvenient from a “political” point of view, since it made it difficult to internally defend generous country frame budgets which year in and year out were not fully utilized by the recipient country (or sector). Even though development cooperation during the 1980's had a very reasonable slice of the Swedish government's budget cake, country and sector priorities could always change according to which direction the political was blowing. But Angola, being recently independent and one of the front-line states bordering apartheid South Africa, was one of the privileged cooperation partners whose country frame was not supposed to be subject to cuts.

It soon became evident that the MoH was lacking management capacity to use the allocated funds according to agreed plans. Only half of the allocated 40 MSEK of the first agreement 1979–1982 was in fact utilized, since only the programmes that included hardware, like vehicles and equipment, etc. could mobilize enough “spending capacity”.

Through the years, it has been difficult to monitor implementation of the programmes, since there were no reliable methods to collect data from the field (see for example *Appendix 3* about the Angolan evaluation 1991). In some instances Sida was also sceptical about the Ministry's proposals and priorities. Despite scepticism and uncertainty about results, the Swedish government and Sida did not hesitate in maintaining, or even increasing, the budgets without any more profound analysis together with the Angolan party. We know today that the Angolan party was worried about Sida's focus on disbursement instead of contents and performance, but it is not clear whether the Angolan party ever brought up the issue during the quarterly or annual discussions in Luanda.

A huge part of the support went to equipment and vehicles and the highly technical projects were prioritized, e.g. the malaria programme which needed laboratories, as opposed to low-budget support like training and compe-

³⁵ This is no longer possible since the Swedish budget system was reformed and the fiscal year from 1997 coincides with the calendar year.

tence development, management support, etc. One of the Swedish advisers remembers a budget discussion, when Sida insisted in allocating an extra million to the malaria programme for no other reasons than spending. This imbalance in favour of hardware as opposed to software was also discussed in the 1991 evaluation. But the evaluation was made when the programme had been running for eleven years, and the adjustments that were made soon after were rather motivated by the intensified war than by a thorough analysis based on the findings of the evaluators.

A palpable example is the huge investment in the training programme in Luanda, which started in 1986. Both Sida memos and interviews clearly indicate that Sida initially did not agree to the Angolan proposal to support training of middle level nurses (*técnicos médios*), who would most certainly not work within the poorly developed PHC system. Sida preferred to support training of assistant nurses (*técnicos básicos*) who, realistically, would continue being the pillar of the health system during a foreseeable future. In addition, it was also well known that the medium level institutes mainly functioned as springboards to the Faculty of Medicine or other academic courses. In addition, a middle level course gave the right to more generous rations of food and consumer goods. Nevertheless, Sida embarked on the most resource consuming programme of all, with a large number of Swedish nurse tutors and a considerable amount of vehicles and equipment to make the training institute function. In an analysis *a posteriori* one is inclined to question whether this venture was a conscious and well-founded investment or if it was guided by pressure to maintain a generous health support budget in Angola.

Table 10, Disbursements per fiscal year/year 1979–2005

Year	MSEK	Year	MSEK
1979–80	5	1992–93	36
1980–81	11	1993–94	29
1981–82	5	1994–95	11
1982–83	4	1995–96	51
1983–84	17	1997	32
1984–85	11	1998	36
1985–86	8	1999	49
1986–87	25	2000	37
1987–88	28	2001	30
1988–89	31	2002	28
1989–90	47	2003	19
1990–91	36	2004	16
1991–92	37	2005	28
		Total	667

After analysing allocations and disbursements through the years we are inclined to believe that the “disbursement goal” had a strong influence on budget levels as well as on the choice of programmes to support. At the time, this seems to have been an inbuilt contradiction in Swedish development cooperation, not only in the case of Angola but also in many other countries which, because of their low technical and administrative capacity, have had problems using allocated funds in a timely and planned way. In our view, too much money at a time might not stimulate an equitable and socially just development, but rather open for misuse of resources while overlooking necessary national efforts.

Sida’s “disbursement goal” created more problems than it has solved, since its focus was on the money and not on implementation capacity and quality on the Angolan side. In that way, the cooperation in the health sector got off to a bad start. There were early signs showing that the national programmes could not reach out to the provinces as foreseen, and that capacity at provincial level was far lower than in Luanda since few health staff had sufficient background training and supervision was lacking. To strengthen capacity at an early stage, Sida should have proposed more “software” in the form of systematic technical and management training at different levels. This would certainly have meant more hard work – for both parties – and less spending, but it would have paid off for Angola in the long run.

Efficiency and effectiveness in war times

Has the Swedish development cooperation contributed to improved health in Angola? This is one of the questions behind this study, but we must state that our study cannot present any accurate response to it. Stating this does not mean that there is no such answer, just that it has to be researched by a more profound and extensive study.

During the twentyseven years (1979–2006) of support to the health sector, Sida has disbursed MSEK 667, although the total budget amount was considerably higher. It is, however, not possible to evaluate the efficiency of the support and calculate the output, e.g. in terms of immunized children and pregnant women or graduated nurses from the *Instituto Médio* in Luanda. Firstly, because we do not have access to statistics that cover the immunization programme and the training programme through the years, and, secondly, even if this had been the case, immunization statistics are not fully reliable, and, in the case of the training programme, there are no data available of the number of graduates who actually remained in the nursing profession (or in the health sector). It would be interesting, though, to make a tracer study of a limited number of graduated nurses to find out where they finally ended up – in the health system as nurses, doctors, or administrators, in other professions in Angola, or if they have emigrated.

Some important factors that have influenced the results – or lack of results – of the cooperation are described in many sections of this report, as e.g. centralization and bureaucracy, lack of management capacity and experience, lack of health workers and low professional level, corruption in the system and lack of discipline, etc. But the main factor to obstruct all development efforts in Angola is the war which also, partly, is behind so many of the other problems affecting the Angolan society since Independence. It has consequently never been possible to implement the health programmes – whether vertical or horizontal – with full efficiency and effectiveness. But our review, nevertheless, shows that some measures could have been taken by both sides to improve performance and use the available resources in a more rational way.

The Angolan evaluation report (1991) states that *“the programmes are not familiar with the universe in which they are supposed to intervene”* and it seems like the same goes for Sida. Sida mainly used medical expertise for consultancies and as members of delegations during the annual consultations. As far as we can see, no social scientists, such as sociologists or anthropologists have been involved which, for example, was the case in the Angolan fisheries programme. Participation from the social sciences could have enriched not only Sida’s understanding of the Angolan universe, both also contributed to a deeper knowledge for both sides about attitudes among men and women to some of the complex issues the health programmes were dealing with, such as immunization, pregnancy and childbirth, family planning, Western school medicine versus traditional practices, etc.

It is also an amazing observation that Sida made the first evaluation of the health support only after twelve years, in 1991. If evaluations are to be used as constructive contributions and useful tools for improvement, they should be made at shorter intervals and must be broadly discussed among stakeholders. This was not the case neither with the Swedish evaluation report, which was very little circulated in Sweden, nor with the Angolan, according to the information we have got. But, irrespective of what happened with the written reports, those Angolans in leading positions had a responsibility to point out problems regarding implementation to Sida, since any cooperation effort must build on trust and must stand a frank discussion of problems on both sides.

Results in spite of all

These two examples above – immunization and nurse training – also illustrate the problem of analysing whether objectives have been achieved or not, programme by programme. What we know, however, is that Sida’s initially defined objectives to help building up a nationwide PHC system has not been achieved. But some important components of such a system have developed in an efficient way, thanks to strategic and comprehensive support

from Sida and other agencies or NGOs, and, above all through well-functioning management and dedicated work from the Angolan staff. This is the case of the Essential Drugs programme and the comprehensive Maternal and Child Health programme in Luanda, with the decentralized maternity and paediatric wards and the specialized midwifery course. We do not have the full picture, but the tendencies are positive.

We want to underline that a serious assessment of results in Angola is practically impossible. When, for example, studying the available data regarding maternal mortality, which is absolutely one of the most burning issues in Angolan society since many years back, we can only get data from the Maternity Hospitals and Health Centres in Luanda province, i.e. the institutional deliveries and the institutional maternal mortality rate. And for a couple of years, the National Maternity Hospital Lucrécia Paim did not even kept statistics of maternal mortality³⁶, i.e. one of the absolutely most important parameters to monitor quality and development of maternal health services (and a very important indicator of overall performance of any health system in any country).

Demographic data for Luanda province are also very inexact, to say the least. Depending on the source, Luanda's population varies from four to six million inhabitants, which means that the number of pregnant women is unknown, as well as the number of home deliveries and, consequently, the extra-institutional maternal mortality, especially since there are no reliable registers showing causes of death. The same goes for extra-institutional infant and child mortality.

There are, however, clear tendencies showing that the peri-urban maternity wards are receiving more and more pregnant women for antenatal care and that the number of women giving birth at a Health Centre has been increasing during the last years. Although this has not palpably unburdened the two big hospitals in Luanda, which are still chaotically crowded mainly by women with normal deliveries, the situation at these hospitals would certainly be out of control without the peri-urban services functioning. The same effect is expected to happen through the decentralized paediatric wards, so that the National Paediatric Hospital can concentrate on the seriously ill children. There is also said to be an interest in other provinces to replicate the Luanda model and build up decentralized reproductive health services.

When looking back at the programmes that were phased out by Sida in the 1990's, they are still surviving and performing with more or less energy. It is, though, practically impossible to isolate the effects of the Swedish support, ten or more years after it was phased out. Many programme managers confirm that the Sida support was welcome and helpful at certain critical moments, especially before other donors started supporting the health sector, which mainly happened after the political changes in 1992.

³⁶ During the period when the hospital was being rebuilt.

Is improved health possible in war and absolute poverty?

It is the responsibility of the Angolan government to guarantee the welfare of the citizens, and external support should not be the decisive factor whether children survive or whether women die during childbirth.

Health care in colonial times was certainly not for all, and what was taken over by the Angolan government after Independence was, by no means, a well functioning system. But during the protracted war, the health organization rapidly eroded from the already low pre-Independence level, and ended up with its infrastructure in shambles and a severe lack of staff, equipment and drugs. As we have seen, the Angolan government soon approached multilateral and bilateral donors asking for support to maintain activities to combat the endemic diseases, and later to other components like import of essential drugs, training for the medical professions, maternal and child health, and much more to add.

Health depends on a broad spectrum of social, economic and cultural factors, which have made Angola's health indicators some of the worst in the world. This means that Angola's catastrophic health situation cannot be seen as an isolated problem, but has to be analysed together with the extreme poverty, the overpopulation of Luanda³⁷ and other urban centres, the health-impairing environment, the lack of clean water and the low educational level of among the population. Peace and stability are the most important prerequisites for people to be able to cater for themselves and their families, at community and individual level.

³⁷ According to official data from the Provincial Health Delegation of Luanda, it is estimated that Luanda province had got approximately 5,4 inhabitants in 2006

Lessons learned

A slow awakening

Lack of realism

There is a lot that points towards a lack of necessary information when Sida started planning the first agreement for support to the Angolan Health sector. Consequently, Sida was unable to make a realistic appraisal of the possibilities to contribute to building up a national PHC system to reach the main target group, the rural poor. Even the Angolan government lacked information about the situation outside Luanda, and seems to have had rather vague ideas about how to organize health services. The civil war was a reality, yet it took a long time before Sida realized – or wanted to accept – that it was not possible to reach out to all the provinces with the centrally managed programmes, such as Endemic Diseases and Immunization.

From an initially broad scope, Sida step by step narrowed down its support, and most activities were concentrated to Luanda province. From the beginning of the 1980's, Swedish advisers, with coordinating and other functions, were placed in the MoH, but no Swedish field staff was ever placed at provincial or local level.

From hope to despair

In the early 1990's, when there were general hopes of peace, Sida started a tentative discussion about planning for a programme to support the Benguela province. After the outbreak of a full-scale war again, in 1992, all such plans were shelved and Swedish technical assistance was drastically reduced. All support was deliberately focused on Luanda.³⁸

While Swedish health personnel always remained in Luanda, the programmes tried to function in the provinces with plans varying according to the security situation, and not mainly according to the needs of the population.

It is a fact that there were very few options for international agencies working in Angola during the war. It was not possible to implement development programmes in a situation of instability, which initially had been Sida's objective. Outside of Luanda, most of the agencies and NGOs were working

³⁸ In 1998, Sida initiated a rehabilitation programme in Malanje province. This programme had to be phased out after less than a year when the war intensified again.

with an emergency or humanitarian approach, and Sida eventually reformulated its programme from development to emergency support after 1992.

Health support without a clear policy

Social sectors undermined

Sida's support has not made any significant contribution to the development of a Primary Health Care system along the guidelines formulated in Alma Ata (1978). This can partly be explained by the fact that Angola has been involved in a practically permanent war since Independence. The lion's share of the resources (through the official government budget) has been spent on warfare and the social sectors have been severely undermined by very limited allocations. In its dialogue with the Angolan party, the Swedish Embassy has now and then underlined the government's responsibility and the need to increase allocations to the social sectors, but such discussions have been without effect. The eternal salary and maintenance problems can, in fact, not be solved by external donors.

Lack of resources for PHC

Another reason for the limited success is that Angola, at the time of Independence, was lacking all kinds of resources needed for establishing a PHC system worth the name. There was virtually no health staff left in the country, since most of the few qualified people had abandoned Angola after Independence. The colonial health system was a shambles, and the new government had not even any exact information of existing infrastructure, or of health staff remaining in the country. Moreover, the colonial system had a strong hospital bias and was thus not oriented towards prevention and PHC.

When Sida launched its comprehensive health support most of the components could be objectively interpreted as parts of a PHC system, such as "basic health care", immunization, combat of endemic diseases, and essential drugs. But in spite of the PHC character of the programme, these components were not coordinated horizontally to help building a functional PHC structure.

Vertical programmes – no coordination

Several of the programmes supported by Sida were, from the beginning, organized as vertical programmes, which is not an ideal model when creating a PHC system. But in the precarious situation just after Independence this was probably the emergency solution – better vertical programmes than no programmes at all. Angola immediately needed to combat the endemic diseases – malaria, TB/leprosy and trypanosomiasis – and introduce a national

immunization programme for preventable diseases, and Sweden and the UN agencies accepted the challenge. The already existing centrally managed programmes for combating the endemic diseases were maintained, and the immunization activities started through UNICEF's vertical EPI model.

Early on some of the Angolan specialized professionals were aware of the negative effects of the verticalization, but since all programmes received their own budgets (not only from Sida, but also from other agencies) the consequence was that programmes “*arrived at the Health Centres*” in a vertical way and coordination became difficult, especially with the lack of organizational experience among health workers in the field. The Angolan evaluation clearly states the difficulties in handling the vertical programmes at the Health Centres. There were no coordination meetings at the Centres and the lack of experience among health staff, and especially the hierarchical system made it difficult to work in horizontal integration so that the scarce resources could be used in a more rational way. (*Pinto, 1992*)

For more than one decade, Sida continued supporting the core programmes but without being able to influence the Angolan authorities to introduce methods for real coordination between the programmes at Health Centre level to create a PHC “package”. Even today, more than thirty years after Angola's Independence, there is still little coordination between the different “classical” vertical programmes, which creates problems in the daily work at Health Centres and Posts since health workers are divided up between the programmes and material, vehicles and other resources can thus not be used in the most rational way.

Overestimation of Angolan management and technical capacity

No analysis of management capacity

The initially optimistic and solidarity based approach made Sida overlook the complexities of the Angolan society and especially the health sector. Sida did not understand the overall weakness of the Angolan health institutions and of the government structures. There are no traces of any analysis of the institutional and management capacity on the Angolan side to implement the rather advanced programmes. The combat of the endemic diseases required not only doctors and nurses, but modern laboratories with trained staff and also health workers with pedagogical ability to disseminate health messages well adapted to the educational and cultural level in each community. These human resources did not exist in the beginning, and, equally, there were no experienced managers in the MoH organization. The exception was the trypanosomiasis (sleeping sickness) programme, which had a well-established methodology and was directed by a medical specialist who had remained in the country to continue his work.

The consequence of this lack of awareness from the Swedish side was not only a slow implementation of the agreed activities, but also a delay in introducing necessary management practices. Sida required a certain level of planning and reporting (financial as well as activity), but little was done to help developing these competencies. Angolan MoH staff were, themselves, conscious of their shortcomings but more hands-on instructions and training does not seem to have been introduced before the mid-1990's, when the implementation consultant InDevelop started coordinating the support programme which eventually was concentrated to the Luanda province.

Why not training and competence development?

The Swedish support should have needed strong components of training and competence development already from the beginning to promote the development of the health sector and its institutions with a step-by-step approach well adapted to the realities in Angola at the time.

Institution building was evidently not the strong point of the Swedish support, but it is not clear whether this was due to Swedish negligence or Angolan lack of interest (or resistance to interference in a “political” area). When the Swedish support, after 1992, gradually changed character from development to humanitarian assistance, the institution building aspect was downplayed since the support became more project-oriented. From the development of CAOL and CAPEL it is however possible to discern some efforts to strengthen systems and management, although this area should have needed more time to develop and become sustainable.

Development on an upward slope

The colonial legacy

Angola achieved its Independence after over twenty years of armed struggle against Portugal. The colonial power itself was one of the most underdeveloped nations in Europe, with a primitive economy to a large extent based on agricultural products and extraction of primary produce from the colonies. Portugal was the last European colonial power and, in addition, a fascist dictatorship since the early 1930's, when the *Estado Novo* (New State) was proclaimed. The Portuguese colonial system is usually regarded as having been much more backward and primitive than that of the British and the French in the African colonies, which also mostly became independent in a more peaceful way.

The public administration strictly followed the Portuguese model, which was extremely conservative and hierarchical as late as in the mid 1970's. This legacy has had a very bad effect on the development of the country and central planning and detailed political control has added to the efficiency problems at all levels of state administration.

Angola's Independence must be seen against a background where the building of a new nation really had to start from scratch. Health and education institutions for the African population were at a low level, while the *colonos* (settlers) of Portuguese origin had access to health care and education of more or less the same standard as in Portugal. The Christian missions contributed with both health services and education, but nevertheless there was only a very narrow élite of well-educated Angolans in the country at the eve of Independence.

No common ground for development

The violent antagonism between the two, and later three, movements that pretended to liberate the country naturally had destructive effects long before the civil war became a fact. It was never possible to create a common ground for a national development strategy, not before and even less after Independence.

When the Portuguese finally gave up Angola in 1975, large parts of the country had already been abandoned by the former owners or managers of the big farms and factories, which were practically all deserted. Equally, civil servants were abandoning their public administration offices; those who left for Portugal had priority when filling vacancies in the ministries in Portugal...

In spite of these cumbersome circumstances, the new government had to meet the expectations of the people, and started launching activities with optimism and mobilized women, men and youth through the mass organizations along the guidelines of the ruling party MPLA. And when the first donors arrived in Luanda, such as Sida and the UN agencies, to participate in developing Angola, they accepted proposals from the Angolan government, or, to be precise, the MoH for supporting the health sector without any deeper analysis.

Understanding the social and cultural context – a must

Weak base for development

Sida evidently wanted to help Angola to, quickly, introduce systems that had very little chances to produce results even in a peace situation because the bases were not solid enough. The country was lacking both human resources and management capacity and had inherited an extremely bureaucratic public administration that was not conducive to smooth implementation of the proposed plans.

There are no shortcuts to progress and development and in Angola conditions were exceptionally trying and the forecasts rather negative. Dr. Britta Nordström, one of the Swedish advisers explains how she felt when working in the MoH:

When I started my work in Luanda, Angola had been independent only fourteen years, which is just a “blip” from a historical perspective. But it seems like Sida didn’t understand or care about that aspect. The country was at war, and it was wrong to give such a heavy support to the central programmes because they couldn’t possibly function. We made field visits to the provinces, and could see that it was impossible to distribute material and equipment regularly – nothing was working. But in spite of this, there was no discussion about the design of the Swedish support. It needed to be changed since the provinces couldn’t be reached, the support needed to be concentrated and so on.

I suggested that we should make community studies, with anthropologists for example, to know more about how people were looking at health and diseases, pregnancy and childbirth, child care, etc., but there was no interest. *(Personal communication, 2006)*

Complex environment

The lack of insight into Angolan social and cultural realities is one of the reasons for the uneven tie-up between the huge input of material and human resources into the Health Programme and the relatively meagre output in the form of more and better health services for the Angolan people. Eventually, someone understood something about the survival strategies among health workers – working, yes, but not at the official workplace – and the system with incentives was established and at least midwives started to work and improve.

This is only one example of the environment in which the Health Programme was implemented. A more careful approach – and less focus on the disbursement goal – would have given time to build up an understanding of the context where Swedish professional know-how and bureaucratic practices were supposed to fit in.

Through the years, Sida has mainly collaborated with the government structures at central level. Planning on the Angolan side has been top-down, and Sida has not questioned the bases for such a planning or shown an interest in participatory planning methods. Sida never tried to adopt a new approach to the problems encountered by evaluators and paid little attention to experiences gathered by TA personnel who was working on the Angolan side.

Few socio-cultural studies

Not even after concentrating the support to the Luanda province such efforts were made, although it would have been completely possible to introduce simple participatory methods e.g. in the maternal health project. There was very little done for learning more about women's own ideas on childbirth and reproductive health in a broader sense. One smaller KAP study (Knowledge, Attitude and Practice) was made in Luanda. Interviews of two groups of women – poor women selling at the marketplace and wage-earning women – revealed that many women had given birth alone, without any help at all. Women who wanted help during childbirth preferred the presence of close relatives or neighbours. TBAs were usually not available – they were very few in Luanda at the time (in the beginning of the 1990's). Most women did not plan for the delivery, mainly because of traditional beliefs, with the consequence that they could not arrange transport when they needed to go to the Health Centre or Hospital.

No systematic learning

There was, however, no systematic learning process based on studies or community work around reproductive health or other important medical fields. During many years there have, for example, been question marks around the half empty peripheral maternity wards. Why do women not use the services put at their disposal? Why do they take unnecessary risks at childbirth? What are actually their preferences when giving birth? Sida never followed up the isolated initiatives to find answers to such questions or to know more about *gasosas* and other unethical practices affecting patients and, in the long run, the results of investments made in the sector. Not even after the evaluation of the Maternal Health programme in Luanda in 1999, which underlined this unsatisfactory state of things, did Sida and/or the MoH make any efforts to analyse the situation further.

Some of the answers about women's reproductive and childbirth behaviour and the professional role of midwives became available in a doctoral thesis 2004. The author is a midwife, Dr. Karen Odberg Pettersson, with a long experience from work in Angola, including a period within the Maternal Health programme in Luanda. Her results will hopefully be of use for the continuing MCH programme in Luanda and for decision-makers at provincial level.

Well-known problems documented

In addition, two of the directors of the DPSL, Dr. Vita Vemba and Dr. Isilda Neves, in 2006 published a local study on socio-economic and cultural barriers that influence women's attitudes and possibilities to seek obstetric care in emergency situations. The study was performed during 2000–2001 in the

Northern Luanda region, and is based on interviews with women in the communities, some traditional midwives and midwives working at the Health Centres in Cacuaco, Kazenga and Viana districts. The study gives a clear picture of the spectrum of problem care seeking women encounter and how health workers try to cope with the inadequate and trying working conditions. *Gasosas* appear as one of the barriers for women to resort to the Health Centre:

The motives that the midwives [in Viana] pointed to as being the main reason for not using the services in time were the lack of transport [and] the anarchical fees charged at the health units (*gasosa*). As to the cost for assistance in the delivery room, it varies between 1,000 and 2,000 Kz and if it is twins one pays the double.

To get the money people resort to their meagre economic resources, which they obtain through petty trade: *“we sell fresh water and other foodstuff.”*

“... According to the business we make to get something to eat ... it’s also enough to protect our lives against illness.”

In case the woman does not have the financial resources, they all unanimously stated that the woman dies in the hospital.

The family member who decides to take the women to the health unit is the husband, and in his absence and when the relations are good the neighbours help.

According to their opinion, the woman is only taken to the health unit when she has no strength or when she needs to be operated or, again, when she is lacking blood or water in the body.

To overcome the lack of money and transport, they resort to the collective taxis and loans from family members or neighbours. Often when it is impossible to arrange transport, the women are carried in hammocks or transported in wheelbarrows.

(Vita Vemba & Neves, 2006, p. 52)

As a motive for the delay in receiving assistance at the Health Centre, the midwives only mention the issue of “anarchical fees”. The interviewed traditional midwives came forward with some constructive ideas to lower the barriers. They suggested that the government should define their situation and status and also make available at least one ambulance for the most distant communities. The ambulance should be controlled by the “Community Coordinator”. In addition, the government should build more health units which should give “first help” to people, as a way of minimizing the “anarchical fees”, because as they said: *“... If the centre is close to our home, they will no longer be able to ask for gasosa, since we will be neighbours.”*

This statement indicates that social control and community based health work is of extreme importance in poor communities where people to a certain extent maintain the traditional social organization, although they live in a setting which is at least semi-urban. People retain their habits and might not always be receptive to health messages that seem totally rational to medical staff or other educated people with a “modern” lifestyle.

Community involvement

There has been too little community involvement in the Maternal and Child Health programme in Luanda – concentration has been on upgrading of Health Centres, training of nurses and midwives, etc. These efforts must not be undervalued, but they are not sufficient to promote safe motherhood. To work directly with the communities is a challenge, but definitely needed to create community trust in the health services provided. *All women*, and when possible men, have the right to get basic information about family planning, pregnancy, childbirth and child care (including hygiene, nutrition and other key aspects). Women must be well informed about how to prepare for the delivery, whether they want to have their baby at home or at the Health Centre.

NGO's, churches and other groups involved in social work should be mobilized to collaborate with the Health Centres and Hospitals to organize work with the communities. Such a task must, however, be based on an attitude of understanding and capacity to dialogue with women and men from all parts of the country, who might stick to traditional practices and be unfamiliar with the public health services. It is not enough to have short sessions of health education at the Health Centres – it is vital to reach those who do not contact the Health Centre because they do not trust the services or simply because they cannot afford to pay the *gasosas*.

Positive developments and remaining problems

We have already expressed many critical views regarding the Angolan-Swedish cooperation, but also mentioned some of the positive effects that can be detected today. We have listened to many stories about what happened during the war, when, for example, all vehicles of the trypanosomiasis programme were taken over by UNITA in the North, or how cars and lots of equipment were stolen in Luanda from another programme – but soon replaced by Sida. Other units equipped and maintained during years by the Swedish programme, such as the printing office of the MoH, were just abandoned by the Ministry because today there are private and more “stylish” suppliers in town. Against the odds, the printing office of the MoH continues functioning, with its old, but well maintained, machinery.

Better institutional capacity

When observing the institutional capacity today one can, however, see a positive development at many levels. The poor Health Centres function relatively well, and, in spite of the existence of gasosas, staff performs well under the prevailing circumstances (lack of equipment and drugs, power failures, lack of information from the provincial level, etc.). Some of the programmes initially supported by Sida have maintained their activity through the years, and seem to have gained impetus after the establishment of peace, which for example is the case of the Trypanosomiasis programme and the Essential Drugs Programme.

Although the infrastructure in the health sector is still weak, some of the institutions involved in the Angolan-Swedish cooperation have been strengthened and their management capacity has slowly developed for the better. Different training projects have contributed to improving the technical and ethical performance of health workers, although quality improvement is a slow process. Another example is the training institutions which got an important input in the form of teachers and directors with an appropriate theoretical and pedagogical upgrading, through the grant to study in Brazil during the 1990's. These positive effects can serve as a platform for further efforts to promote PHC services for the Angolan people.

Sida's policy: To work within the institutions

Among the positive experiences we want to underline Sida's policy to work with and within the Angolan institutions, which was also specifically mentioned by some of the interviewed persons. Sida avoided to "take over" persons in leading positions, like some other agencies or NGOs do. The Swedish model was to try to strengthen and consolidate the Angolan structures through coordinators and advisers based in the MoH, improved working environment and technical input, training, etc. This system partly changed from 1995 and onwards, when the Programme was implemented by InDevelop, which created its own administration, although the long-term planning was made together with CAOL and later also with CAPEL.

Another example of Sida's policy and attitude is that the supported programmes were not bound to make their purchases from Sweden. The Trypanosomiasis programme could import Japanese cars – and would, moreover, never have been able to transport its mobile teams in Volvo or SAAB cars – and the maintenance was facilitated by the simultaneous import of the most frequently used spare parts.

People are sustainable

One of the interesting observations during this study is, however, about the people who have been involved in this long standing cooperation effort in the

beginning or more recently. While cars are run down in few years on the streets of Luanda, people are more robust and durable. All the over forty people we could interview are still working as doctors, directors or teachers and none of them has abandoned the health sector. Many of them appreciate the professional exchange with Swedish colleagues, and some tell about their hard work with planning and budgeting to live up to Sida's strict rules! They have gone through their own development process – quite a few of them with support from Sida – and they are today a very valuable asset for the Angolan health sector.

Lack of human resources

The MoH has, though, lost some of its qualified staff at high or middle level to UN agencies, World Bank projects and the EU, but these people are at least still present in the country. It is not likely that Angola will suffer from such a serious brain drain like e.g. Ghana, which has lost immense numbers of health staff to the UK and other English speaking countries. In Angola's case, the outlet would be Portugal or Brazil, or the other Portuguese speaking African countries, but these alternatives are usually not attractive enough compared to the possibilities offered by the private health sector in Luanda.

Three decades after Independence, the Angolan health sector is, naturally, better off regarding human resources. But thousands of more doctors, nurses, midwives and administrators/managers are still needed in the public health system, and the situation is especially dramatic in the provinces, since doctors and other categories prefer to live and work in Luanda. And since a long time back health workers at all levels in the public system do usually not carry out their duties during a full working-day but spend several hours per week in privately run clinics.

The future

Since the war and its social and economic consequences has obstructed most attempts to systems and institution building, the national health system remains without the necessary financial resources. Today, Angola needs to establish a broadly supported, comprehensive, and socially just health policy and start (re)building health institutions more or less from scratch and with a strong community involvement. This has to be done through a national effort and with national resources, since peace and stability and the country's macroeconomic indicators give enough evidence that Angola will be able to stand on its own feet if there is a genuine political will to do so.

Appendix 1 Terms of Reference

1. Introduction

The Swedish government has decided that the bilateral development cooperation with Angola in the health sector is phased out in March 2006. The present Terms of Reference represents the guidelines for the mapping and analysis of the Swedish support to the health sector in Angola 1977–2006.

After the finalization of three decades of bilateral health support, there is a need and an opportunity to document how the health sector in Angola has developed. This study shall be based on a description and an analysis of development in Angola throughout the period. It shall also focus on the Swedish support that was decided upon and implemented in response to development in Angola and the Swedish policy changes. Thus, the study will cover different actors and their actions in Sweden and in Angola.

2. Background

Sweden has been involved in program support to the health sector in Angola since 1977 and during most of this period the country has been in a situation of varying degrees of civil war. After almost thirty years of war, peace was finally proclaimed in 2002.

Sweden has supported the Angolan health sector for almost three decades, and the nature of the support has changed over time. The period 1977 to 1982 focused mainly on primary health care. During 1983 to 1985 an extensive programme was prepared that started in 1986 and continued until the civil war broke out again after the elections in 1992. The programme included support to infectious diseases programs like malaria, tuberculosis and sleeping sickness as well as immunization program, essential drugs, nurse training and public health planning.

Due to the severe war situation in the country in 1992, the health support had to be narrowed down from 1993, and focused on maternal health, and from 1997 also on child health, in the Luanda Province, as well as to a mid-wifery school. The overall aim of the support was to reduce child and maternal mortality rates, which were some of the highest in the world, by increasing access to Maternal and Child care in the suburbs of Luanda.

After that Swedish health development cooperation has ended with Angola, two studies has been commissioned; one which is focusing on the phasing-out period of the Swedish health sector support during 2004–2006 and this study

which is focusing on the entire experience of Angolan-Swedish cooperation for almost three decades and provide a general overview of its advances and setbacks.

3. General objective and purpose of the study

The general objective of the present study is to review and analyze the motives and methods of the Swedish health support to the health sector in Angola. In order to get a general idea of its overall appropriateness and relevance, the study should begin roughly assessing the degree of the effectiveness and the reasoning behind the choice of support. The study shall document and analyze three decades of Swedish health support to Angola, from 1977 to March 2006.

The resulting report and the information gathered in the process will serve the following purposes;

- to provide a written legacy of the motives behind the Swedish support in the Angolan context and lessons learned from the health support over such a long period.
- to provide documentation and analysis of results of the Swedish support.

4. Issues to be studied

The following issues shall serve as a guide-line in carrying out the study.

In terms of effectiveness, to what extent and in what way has the Swedish development cooperation contributed to improved health in Angola?

A strategic perspective should be applied and the analysis to the extent possible be based on existing evaluations, reviews and studies and what can be learned from such a long cooperation.

For material, the study shall take into account material and interview data from both the Swedish and the Angolan side. The analysis shall focus on the actions of both sides, and shall also attempt to produce conclusions that may be relevant to them both. Additionally, the study shall take into account the views of other international cooperation agencies present in Angola.

5. Expected results of the study

The study shall present the following results:

- A systematization and documentation of relevant existing information and knowledge, preferably in the form of a broad description of the health support and development in Angola during the period 1977–2006

with examples of different activities and processes that received support.

- a description of the results obtained in the health sector in Angola
- an assessment of the degree to which the Swedish support to the health sector in Angola has been effective and has contributed to the results achieved.
- a concluding discussion, summarizing the findings and pointing to the main conclusions and lessons learned for the Swedish support to the health sector in Angola.

6. Methodology

The study shall be based on: (i) written documentation (desk study) and (ii) interviews with persons in Angola, Sweden and elsewhere, relevant for the study.

After preparation and collection of relevant documents from Sida, the main part of the interviews will be conducted in situ in Angola and Sweden. This includes interviews and surveys involving present and former actors in the programme, health staff and health workers representing all components of the programme, representatives from other donor agencies and NGOs, as well as other persons deemed important. The list of persons to be interviewed shall be discussed with local partners.

It is the responsibility of the consultancy to identify and collect relevant material for the study.

7. Competence and skills of consultants

The consultancy team shall possess knowledge of journalism and public health. The team should be Portuguese speaking and possess proven ability of formulating reports that are accessible to the public, thorough knowledge of development cooperation and proven experience of evaluation work and/or similar assignments.

8. Timing, tentative workplan and budget

The assignment should be carried out between May–July 2006

The total number of consultancy weeks is expected to be between 12–14 weeks.

The weeks can be divided between several consultants and Sida welcomes suggestions as to how they should be allocated.

The proposal shall include a division of the number of weeks in work in Sweden and in Angola that the Consultant expects to use for the assignment.

A budget for the assignment, including fees and reimbursables for travels within Sweden and Angola as well as between the two countries should be included in the proposal.

9. Reporting

Prior to the visit to Angola, an inception report shall be presented to Sida, how the consultant intends to address the assignment and the assignment is conditioned of the approval by Sida.

The consultant team shall submit a draft version of the report to Sida and the Embassy not later than 7 August, 2006.

The draft report shall be submitted to Sida electronically and in three hard copies. Sida shall within two weeks submit any comments to the draft report. Within two weeks of receiving Sida's comments on the draft report, a final version shall be submitted to Sida, again electronically and in five hard copies.

The report shall be written in English and then translated to Portuguese and shall not exceed more than 60 pages. The study must be presented in a way that enables publication without further editing, and have been professionally proof-read.

Appendix 2 List of interviewed persons

In Luanda

Ministry of Health

Dr. José Vieira Dias Van-Dunem, Vice Minister of Health,
Ministry of Health

Dr. Constâncio João, Deputy Director, Essential Drugs Programme

Dr. Adelaide de Carvalho, National Director for Public Health,
former Programme Coordinator CAOL

Dr. Engrácia de Freitas, Coordinator,
Course for Specialization of Midwives (CEP)

Dr. Filomena Wilson, Head of the Health Education Programme,
Department of Health Promotion

Dr. Lino Silili, Director General, Technical Vocational Health School of
Luanda; former Coordinator Nursing Course, Medium Level Health
Institute of Luanda

Dr. Luzia Fernandes Dias, Director General, National Blood Centre

Dr. Jorge Manaças, Director, Essential Drugs Programme

Dr. Constâncio João, Deputy Director, Head of Logistics,
Essential Drugs Programme

Dr. Aida de Menezes, Head of Section for Child and Adolescent Health,
National Directorate of Public Health

Dr. Ducelina Serrano, Director, Institute for Combat of HIV/AIDS

Dr. Daniel António, National Director, National Directorate of Drugs and
Medical Equipment

Mr. António Ferrão, Head of the Printing Office

Dr. Ana Vaz, Director, Department of Hygiene and Epidemiology,
Environmental Health and EPI; former Director of the Malaria
Programme, Directorate for Control of Endemic Diseases

Dr. Evelise Fresta, National Director of Human Resources

Dr. Constantina Furtado, Head of Department for Human Resource Development

Dr. Maria José Cardoso, Head of Training Section

Professor Théophile Josenando, Director Institute for Combat and Control of Trypanosomiasis, former Director of the Trypanosomiasis Programme, MoH

Dr. Kiassekoka Nlemvo Miguel, Public Health Adviser to the Deputy Minister of Health; former Head of Department for Primary Health Care, MoH

Dr. N'Doza Kulosa Luwawa, Coordinator HAMSET Project, Planning Department of the MoH; former Head of Department of Maternal and Child Health and Family Planning, National Directorate of Public Health, MoH

Dr. Joseph Nsuka, Director, Tuberculosis and Lepa Dispensary in Luanda

Provincial Directorate for Health in Luanda (DPSL)

Dr. Vita Vemba, Director, Provincial Directorate for Health in Luanda; former Coordinator of the Institutional Support Project

Dr. Maria Isabel Massocolo Neves, Head of Section for Primary Health Care, Provincial Directorate for Health in Luanda; former Programme Coordinator CAOL

Dr. Isilda Neves, Director for Public Health, Provincial Directorate for Health in Luanda; former Programme Coordinator CAPEL

Dr. Catarina Oatonha, Coordinator of the Immunisation Programme and the Programme for Health Promotion, Provincial Directorate for Health in Luanda

Mr. José Mobiala, Head of Transport Section, Provincial Directorate for Health in Luanda

National and General Hospitals

Dr. Abreu Pecamena Tondesso, Director General, Lucrecia Paím Hospital

Dr. Pedro de Almeida, Lucrecia Paím Hospital; former Director of the Health Education Programme, MoH

Dr. Florinda Silva, Lucrecia Paím Hospital; former Pedagogical Director, Medium Level Health Institute of Luanda

Dr. Jerzy Niekowal, General Maternity Hospital Augusto N'Gangula

Dr. Luís Bernardino, Director, National Pediatric Hospital David Bernardino

Others

Dr. Raúl Feio, Programme Officer, EC delegation, Luanda

Dr. Rui Pinto, Administrative Director, Clínica Sagrada Esperança;
Senior Lecturer, Department of Public Health, Faculty of Medicine;
Author of the Angolan Evaluation of the Swedish Health Support
(1991)

Dr. Júlio Leite, UNFPA; former National Director, National Directorate of
Public Health, MoH

Dr. Gabriel Simas, UNFPA Gender Specialist

Dr. Paulo Muzuza, UNFPA, HIV/AIDS Programme

Dr. José Ribeira, UNFPA, Demographer

Professor Paulo Campos, Faculty of Medicine, Universidade Agostinho
Neto; former Coordinator CAOL

Dr. Joaquim Malungo, ADPP, Programme Officer HIV/AIDS Programme;
former Director of EPI, National Directorate of Public Health, MoH

Dr. Jorge Dupret, former National Director, National Directorate for
Control of Endemic Diseases, MoH

Dr. Ana Maria Domingas Pedro, Student at the Faculty of Medicine,
Universidade Agostinho Neto; former Assistant Pedagogic Director,
Medium Level Health Institute of Luanda

Dr. Fernanda Dias, Clinic Superintendent of the Department for Infectious
Diseases, Hospital Américo Boavida; former Director of the Malaria
Programme, Directorate for Control of Endemic Diseases, MoH

In Sweden

Sida

Mrs. Lena Johansson Blomstrand, Counsellor, Embassy of Sweden in
Namibia; former Counsellor, Embassy of Sweden in Angola

Mr. Rolf Folkesson, Head of Division for Contract-Financed Technical
Cooperation, Sida Headquarters; former Head of the Development
Cooperation Office in Angola

Dr. Britta Nordström, Programme Officer, Health Division, Sida
Headquarters; former Programme Officer, InDevelop Sweden;
former Adviser, National Directorate of Public Health, MoH

Others

Mrs. Carin Norberg, Director of the Nordic Africa Institute;
former Head of Department, Sida

Mr. Dag Ehrenpreis, International Poverty Centre, United Nations
Development Programme/ Institute of Applied Economic Research,
Brazil; former Head of the Development Cooperation Office in Angola

Mr. Lars Boberg, Retired; former Programme Officer, Health Division and
Regional Department, Sida Headquarters

Mrs. Lise Munck, Consultant; former Programme Officer, Health Division,
Sida Headquarters

Mrs. Kerstin Fransson, Consultant; former Counsellor, Embassy of Sweden
in Angola; former Programme Officer, Development Cooperation
Office in Angola

Mr. Bernt Andersson, Consultant; former Head/Programme Officer,
Division of Health, Sida Headquarters; former Adviser, Planning
Department, MoH

Mrs. Eva Hedberg, Nurse Tutor; former Nurse Tutor at the Course for
Specialization of Midwives (CEP); former Nurse Tutor at the Medium
Level Health Institute of Luanda

Professor Staffan Bergström, International Health Care Research
Unit/IHCAR, Karolinska Institutet, Stockholm; former Consultant to
InDevelop; former Consultant, Health Division, Sida Headquarters

Mrs. Kristina Snoder, Midwife, former Adviser CAOL,
Provincial Directorate for Health in Luanda

Mrs. Kerstin Bertilsson, Retired; former Representative/Administrator
InDevelop Luanda; former Adviser, Planning Department, MoH;
former Human Resources Planner, MoH

Dr. Anna-Karin Karlsson, General Practitioner; short-term Consultant to
Sida; former Adviser National Directorate of Public Health, MoH

Persons interviewed in Luanda in April 2006

National and General Hospitals

Dr. Rosa Maiato, Augusto N'Gangula Hospital

Ilha de Luanda Health Centre, Ingombota District

Mrs. Noela Guimarães, Nurse, Youth Counselling Service

Mrs. Ilidia Benedito, Nurse, Youth Counselling Service

Mrs. Paulina Nguinamau, Midwife

Mrs. Maria da Conceição Tomás, Midwife

Ana Paula Health Centre, Viana District

Mrs. Teresa P. Belchior, Midwife, Responsible Delivery room

Dr. Ana Generosa Hungulo, Director

Mrs. Ana Cristina Romão, Midwife

Kilamba Kiayi Hospital, Kilamba Kiayi District

Mrs. Felícia Júlio, Nurse

Mrs. Evalina Politano, Nurse

Dr. Judite A. Venâncio, Clinic Superintendent of the Hospital

Mrs. Luisa Edgarda, Midwife, Responsible Delivery room

Mrs. Maria de Lourdes, Midwife

Mr. Seke B. Eduardo, Supervisor

Dr. João Luz, Obstetrician

Cajueiros Hospital, Kazenga District

Mrs. Maria Alexandre, Midwife

Mrs. Lizete Pinheiro, Hospital supervisor

Mrs. Joana Quiosa, Midwife

Mrs. Sebastiana António, Hospital attendant

Dr. Claudina Francisca, Obstetrician

Mrs. Domingas Valente, Nurse

Mrs. Vanda Maria, Midwife

Mr. Faustino Rodrigues, Nurse

Mrs. Júlia Cassinda, Nurse, Responsible Surgical Appliances

Others

Dr. Adelaide de Carvalho, National Director for Public Health, MoH;
former Programme Coordinator CAOL

Ambassador Anders Hagelberg, Embassy of Sweden in Luanda

Mr. Tom Abrahamsson, Programme Officer, Embassy of Sweden in Luanda
Dr. Dário Pontes Regis, Consultant, InDevelop
Mrs. Maria da Conceição Barros do Rosário, Midwife, Manager,
Course for Specialization of Midwives (CEP)
Mrs. Ana Chilepa, Midwife, Teacher, Course for Specialization of
Midwives (CEP)
Mrs. Domingas Beatriz Borba, Teacher, Course for Specialization of
Midwives (CEP)

In Caxito, Bengo Province

Dr. António Moyo, Head of Department of Public Health,
Bengo Provincial Hospital
Dr. Albertina Menezes, Head Department of Obstetrics and Gynaecology,
Bengo Provincial Hospital
Dr. M'bala Cussumo, Director, Provincial Directorate for Health in Bengo
Dr. António Martins, Director, Bengo Provincial Hospital
Mrs. Sofia Simão Rodrigues, Head Nurse, Pediatric Department,
Bengo Provincial Hospital
Mr. Coxe André, Nutritionist Nurse, Pediatric Department,
Bengo Provincial Hospital
Mrs. Madalena Amaral, Nurse, Pediatric Department,
Bengo Provincial Hospital
Mrs. Catarina Catí, Nurse, Caxito Health Centre, Bengo Province

Persons interviewed in Sweden in April 2006

Sida

Dr. Anders Molin, Head of Health Division
Mrs. Ewa Nunes Sörenson, Programme Officer, Health Division
Mrs. Susanne Spetz, Programme Officer, Africa Department

Others

Mr. Roland Svensson, Consultant, former Sida Programme Officer,
Swedish Embassy in Luanda
Mr. Kent Jönsson, former Representative of InDevelop, Luanda

Appendix 3 The Angolan evaluation 1991 – summary

The Angolan evaluation team interviewed directors and staff in all programmes that received support in 1991:

Essential Drugs – EDP	Extended Programme of Immunization – EPI
General Support	Health Education
HIV/AIDS	Malaria
Maternal and Child Health – MCH	Training
Trypanosomiasis	Tuberculosis – TB

Evaluation of programme results by managers at central level

A general impression from the evaluation is that the *Essential Drugs* programme is functioning better than many of the programmes and staff says that the programme has reached out to many districts, although it is still not possible to reach the whole country. There is also a problem with the training of health staff in the rational use of the drugs supplied by the programme.

The targets set by the *Extended Programme for Immunization* were not met. In Luanda Province coverage varies between 38% and 60%, while the figures for the whole country are between 31% and 47%. The reasons mentioned are the deficient organization of the programme, but also “social difficulties” related to the war and the fact that health facilities in many regions are not functioning, which makes it difficult for the programme to reach people.

Through the *General Support* most of the interviewed mentioned that a lot of material has been produced to support the other programmes and it had also been possible to improve the management of the programmes. But nothing was known about the effects of this support at provincial level, let alone at municipal level where Health Centres and Posts are situated.

The *Health Education programme* gives support to the HIV/AIDS programme and, equally, to the MCH programme. Its main activity is, however, training of health staff (nurses) from all provinces and some thirty districts.

The most important activity of the *HIV/AIDS programme* was the building up of capacity for blood testing through a reference laboratory in Luanda and eight laboratories in selected province capitals. It was estimated that the pro-

gramme was covering 45% of the country, but the evaluation team had no possibility to assess the programme activities in the field. Besides testing of blood (for transfusion) the programme had some health education activities at municipal level and was also distributing condoms.

The *Malaria programme* reports a slightly better performance. Basic documentation has been elaborated and health staff, including doctors, from all provinces has participated in training courses. A reference laboratory has been established, as well as a network of laboratories in the provinces. The programme staff states that around 70% of pregnant women receive drugs (chloroquine), but the author of the evaluation report questions the figure for being too high. The malaria programme, like several of the others, does not reach out to the districts, which means that it only works with the Provincial Health Directorates.

The *MCH programme* has not yet been very developed at province level, and no specific results are reported.

Regarding the advancement of the *Training programme*, i.e. the support to Instituto Médio de Saúde, staff reported about the production of textbooks and improved quality of teaching.

The *Water and Sanitation programme* has a very limited outreach, and is only working in Luanda's neighbouring province Bengo, where few results have been produced due to lack of maintenance of the equipment. The sanitation component has not been developed at all. From the *Nutrition Programme* there are no data revealing any concrete results, although it is known that the programme functions in some provinces. The lack of information is said to be due to the badly organized programme. (Because of the limited impact and lack of information, Sida had already phased out its support to these two programmes at the time of the evaluation.)

The *Trypanosomiasis programme* is organised in five sectors, according to the areas with the highest prevalence of the disease and it has nine mobile teams working there with two specialist doctors in the programme. Even so, the programme has only realised 30% of its planned activities and only reached 10% of its target population in the affected areas (mainly in the North of the country).

It is often said that *TB programmes* are difficult to organise and are usually not very efficient. This is also the opinion which is forthcoming from the interviews. There are still no visible results of the TB programme, mainly because of its bad organization, which includes bad utilization of already existing resources. Also the closing down or destruction of health facilities hampers this programme, which needs to get in direct touch with the patients.

Problems encountered at central programme level

How to manage a programme?

Since the cooperation started in 1979 (later in some cases), practically all programmes had changed directors and almost all of the interviewed directors were new at their posts. Only two directors had spent enough time at their posts to be able to organize work and evaluate performance. Among the interviewed directors and other staff many did not know about the documents where programme objectives were supposed to be found, if they were stated in the Sida agreement, in the annual plan, in the plan of operation or in a consultancy report.

Many of the interviewees knew that the original objectives had been reformulated at some point, and the most frequently referred reason was “to improve the organization”, but some also meant that objectives were modified to “make the [programme] more realistic”. Those who believed Sida had influenced this process thought the reason was to improve the coordination between the different programmes, to achieve better quality, and introduce better leadership, planning, control and evaluation. They stated that the changes had made the programmes develop in a positive direction.

During the interviews people came up with quite relevant suggestions pointing at weaknesses that had been observed and debated along the years, e.g. a better definition of target groups of the immunization programme, better supervision in the TB programme, more active vector control in the malaria programme, etc.

Whose needs are met?

It was well known that Sida underlined the need to define target groups for each programme, and especially to make sure that women got access to health services. This was, however, not easy to explain to programme managers and other staff.

Women – especially pregnant women and women of childbearing age – were naturally the target group of several programmes. Besides maternal health, they should also be targeted for immunization and health education. Women should also be focused by the HIV/AIDS programme, since they were considered to play an important role in improving their families’ socio-economic conditions, but also because of “women’s role in the epidemiological chain of AIDS”. (This statement can be interpreted in different ways – either pointing at women as victims of AIDS or blaming them for propagating the disease.)

Infants and young children were, logically, pointed out as the other important target group considering the disease panorama in Angola.

Yet it became evident that it was virtually impossible to specify by age or gender those actually reached or not reached by the programme activities. This was due to the unstable situation of displaced people in all provinces because of the war and lack of updated, reliable population data at province and district levels.

Results and constraints

It was not easy to get a clear picture of concrete results of the programmes, since they are organized in different ways. Some are vertically organized – especially immunization and the endemic disease programmes – and all are centrally managed from the MoH. During the evaluated period from 1979 to 1991 the war was more or less intensive all over the country, so distribution of goods and equipment to the provinces was very irregular. Supervision was equally complicated and many districts were simply unreachable.

For example, central staff could tell what had been implemented by the programmes in Luanda, such as training courses for health staff from the provinces, but reporting from the provinces was irregular. Very little – if anything at all – was reported from the health units that were still functioning in the more remote areas.

More than half of the interviewees meant that their programme had not attained the planned target, or only partly succeeded as far as targets were concerned. The main reasons for the failures had to do with

- Planning, organization, coordination, management and supervision
- War, instability and reduced access
- Lack of human resources, office space, transport and financial resources
- Low educational level and lack of motivation among health staff

The most frequent opinion was that more external assistance would hardly improve the performance and some interviewees mentioned that their programmes had not even used all the available resources. For them “more resources without organization would just be another waste” in this phase.

How to analyse cost-effectiveness in Angola?

All supported programmes had a budget in foreign currency and it was implicit that they should also have a budget in national currency, at least for salaries and running costs. The task of the evaluation team was to find out whether there existed any awareness about budgets and costs, and ideally, about costs in relation to results.

The result of this exercise is somewhat discouraging, but probably very typical for the situation in public administration in Angola fifteen years ago.³⁹ Sida funds were managed by the Planning Department of the MoH and resources distributed to the programmes, which probably had a restrictive effect regarding information about the foreign currency budget.

Of all the 49 persons in leading positions and linked to programme implementation, only 12 confirmed that there was a budget calculation for their programme. The rest of the interviewees said that there was no budget, or that they did not know about such a thing. Nobody knew anything about programme expenditures in national currency!

To test the programme coordinators, the team asked them for the budget amounts in MSEK in 1990. This was evidently an easier task, and practically all coordinators knew fairly well the foreign currency amounts. But in some of the programmes, e.g. Training and Maternal Health, no one could give any information about expenditures. Very few of the interviewees believed that it would at all be possible to make a purely economic analysis of programme performance, i.e. to relate production of health services to available resources.

Improved efficiency – some ideas

Although it was impossible to draw conclusions about cost-effectiveness, people had some suggestions to improve programme efficiency:

- Improvement through staff training
- Improvement of management
- Develop activities to improve technical quality, including research
- Increase investments
- Define objectives and targets
- Improve [physical] conditions of the workplace
- Make better use of consultancies
- Accelerate the process to put an end to the war
- Improve the social conditions of health workers

These ideas give a hint about personal worries, but above all they show a consciousness about what could be done in the short term without too much effort from the MoH. Some persons also brought up some more controversial issues, such as the need to improve the maintenance of existing equipment, the need for coordination between programmes, improved supervi-

³⁹ In the beginning of the 1990's there was no transparency whatsoever, the government budget was confidential and not even directors at national level could inform about the allocation to the health sector (personal communication.)

sion, reduced thefts, better work discipline, and, of course, more cars. Some also wanted to see “a certain Sida bureaucracy” reduced, since Sida sometimes was showing little flexibility.

Horizontal coordination?

The lack of coordination between the different programmes seemed to be a problem for the development of some of the programmes. But when specifically asked about whether there is coordination or not between programmes, the majority of the interviewees answered in the affirmative. But, in reality, not everybody could give examples of coordination, although some mentioned coordination with Health Education, Maternal Health or Essential Drugs. But the main impression is that there was no real coordination and links between programmes, and somebody commented that however much was said about integrated work, all of the programmes went on working “*in their very vertical way*”.

Evaluation of Sida's support

The most important concrete support from Sida, was, not surprising, hardware and other material (reagents, drugs, etc.) because these were the things that made the programmes run. Health Education and the Endemic Diseases programmes were extremely dependent on this kind of support, and Health Education could not even have started without it. Regarding cars, more than half of the interviewees said their programme was totally dependent on Sida.

The absolute majority of the answers showed that the effects of the Sida support were on the whole very positive. More specifically people listed the following positive contributions:

- Material support, such as equipment, drugs, means of transport, etc
- Foreign currency
- Support to organization, coordination and development of the programmes
- Clear and sincere relationship and a serious attitude towards what has been agreed
- Training

However, some could not avoid mentioning the negative aspects:

- Problems with the process of contracting TA personnel, who sometimes do not seem to have the right profile for working in Angola and “for relating to and adapting to our reality”
- Problems with a certain strictness in the relationship, with little flexibility when it comes to approaching and solving questions

- Certain tardiness regarding already agreed purchases
- Impossibility of extending the support to other programmes
- Cutting down support to some of the programmes

In most cases, contact with Sida was through the MoH Planning Department, but a big number of the interviewees had taken part in quarterly or other meetings and some had direct contacts with Sida. Those who complained and wanted more flexibility were mostly working at intermediary level, which meant that their programme director made all contacts. A handful of people also complained about Sida’s exaggerated insistence on financial and other reporting, which they considered a clearly negative factor.

Survival without external support?

There was an almost unanimous opinion that the programmes would hardly survive without support from Sida, but ideas differed about the time span. Maybe the support could be phased out after five years? Some saw the war as the crucial factor for the future of the programmes and whether or not external support was needed.

The most critical areas related to future survival of the programmes were, in order of priority: foreign currency, equipment/material, means of transport and, lastly, technical assistance.

The role of the Swedish cooperantes

Only Essential Drugs programme, General Support, Health Education, Maternal and Child Health and Training had any technical assistance. Besides Swedes Sida contracted some Danes and Norwegians through the years. Five nurse tutors were working at the *Instituto Médio de Saúde* in 1986–87, when the medium level nurse training started. (One of them was working with the basic level course.) EDP had three *cooperantes* – medical adviser, logistician and pharmacist – while the other programmes had one *cooperante* at a time. All in all there were twelve *cooperantes* at the time of the evaluation.

Those who were attached to programmes with technical assistance described the tasks of the *cooperantes* as follows:

Lecturing and training activities	13 ⁴⁰
Planning support	11
Organizational support	7
Management support	6
Production of educational material	4
Development of norms	3
Support in the organization of seminars	3
Support in evaluations	3

⁴⁰ Number of references in interview answers.

As a rule, the TA staff should have a national counterpart, and 24 of the interviewees confirmed that this was the case, while one person explained that there was no Angolan staff with the right profile to work together with the *cooperante*.

The most important results of the TA contribution were:

Lecturing and training activities	10
Elaboration of textbooks, writing texts, organising the library	9
Organizational activities	6
Planning, programming and budgeting activities	6
Programme management	3
Development of norms	2

Rating the most decisive results is, naturally, dependent on the number of persons working with each specific task. Since there were many nurse tutors, training and textbook production are top activities, while only a few people worked in areas where development of norms (MCH and EDP for example) were important inputs from the *cooperantes*.

Were technical assistance to cease, would it be possible to register any positive results of the work performed by the *cooperantes*? Twenty people answered “Yes”, while five did not exactly know and two said “No”. But regarding the daily work, 21 persons meant that the performance was satisfactory. When asked about the biggest obstacle in working with the Swedes, one would guess that the Portuguese language would be the worst problem. But very few referred to language difficulties, and when this was the case it was in the very beginning.

About the social and other benefits, only two persons stated that the Swedes had “exaggeratedly long holidays”.

Eventually, some critical aspects came up, but only from a minority of the interviewees. Some mentioned the relations to Angolan staff, three persons referred to “situations relating to the adaptation to our reality”, others talked about problems with integration at the workplace and, finally, some reacted against lack of consideration/respect for Angolan staff.

Although the Angolan directors and coordinators identified some problems in working together with Swedish colleagues, an overwhelming majority considered technical assistance very important. The crucial areas were public health, training and epidemiology – seven persons wanted an epidemiologist to attend to several of the programmes – but there was also a big demand for managers. The majority, however, held that *cooperantes* did not necessarily have to come from Sweden, and all of these 28 interviewees would prefer specialists from Portuguese speaking countries. And as many as 19 persons thought that the Swedes could be substituted by Angolan staff although they had difficulties in specifying when it would be appropriate to let the Angola staff take partial or full responsibility for the programmes.

The situation in the provinces

None of the visited provinces – Huíla and Luanda – is typical for the rest of the country. Huíla, with its capital Lubango, has historically been privileged with a better infrastructure than other provinces. Luanda has, naturally, benefited from being the province of the national capital, which means being close to the central political power and better access to material as well as human resources.

Huíla – reality is a serious limitation

In Huíla, the team leader Rui Pinto visited the Provincial Health Delegation in Lubango and four Health Centres in the Lubango area (which in reality were functioning at the standard of Health Posts). Besides the Provincial Delegate, he also interviewed the provincial manager of each of the programmes implemented in the province⁴¹. According to his judgement, only two of the programmes, Essential Drugs and Immunization, maintained an acceptable level, i.e. were reaching out to the Health Centres and had regular activities.

The main conclusion about the situation in Huíla is that people in the province during the last few years had gone through an extremely difficult life phase, which would have been even more severe if they had not received aid from donor organizations.

The author identifies several factors that limit the development of the programmes. A fundamental problem is that the programmes are not familiar with the “universe” in which they know the universe where they are supposed to intervene, which makes it difficult to plan activities. Since the information system – from communes and districts to the province level – did not function as foreseen, programme managers had nothing to go on for making adequate and timely decisions. The programmes are thus practically working in a vacuum and, moreover, contacts with the central management through supervision visits are non-existent.

There was no horizontal integration between the different programmes at province, district or commune levels. Each programme worked in a strictly vertical way, which led to defective utilization of limited resources. Both at local and provincial level, health units just function according to their own usual routine, i.e. without work plans with objectives and targets. There was no awareness of costs and benefits of the programmes. Costs in Kwanzas as well as in foreign currency were totally unknown. The programmes were poorly equipped with medical manuals and educational posters, and ordinary office material was lacking. Yet, the programme managers were most worried about the few vehicles actually available, since several vehicles were standing idle in need of repairs.

⁴¹ The trypanosomiasis programme was mainly concentrated in the Northern provinces.

Huíla Province in 1991

At the time, Huíla had about 850,000 inhabitants, 13 districts and 36 communes. There was one Regional Hospital with 400 beds, five other hospitals (paediatric, maternity and psychiatric hospitals, sanatorium and a mission hospital), 21 Health Centres and 73 Health Posts.

The Provincial Health Delegation had nineteen Angolan doctors and 43 *cooperantes*, 375 *técnicos básicos* (assistant nurses), 10 *técnicos médios* (nurses) and 72 upgraded *técnicos básicos*, 195 other *técnicos básicos* (laboratory, X-ray, etc) plus cleaners, etc. In addition, there were no less than 892 administrative staff and 16 staff in leading positions. Statistically, there was 1 doctor per 13,700 inhabitants, but like in other provinces doctors were concentrated to the province capital.

5,750 deliveries (15% of estimated deliveries) took place in institutions, of which 208 were stillbirths.

According to the MoH 1989, the most frequent causes of death were diarrheic diseases, malaria, measles and respiratory diseases. Seven cases of neo-natal tetanus were registered. In the same year, two suspected cases of AIDS were detected, and in 1991 the number of cases had increased to thirteen.

5,500 TB cases were registered, which was almost 30% of all cases in the country, and the 795 cases of leprosy represented more than 20% of the cases in the country. (There could be under-registration in other provinces, and, moreover, Huíla has four leprosaries where the sick concentrate.)

The Health Authorities estimated that there were 40–45,000 pregnant women in the province, and that the anti-tetanus immunization coverage was below 20%. Estimates of 35,000 children <1 year of age showed an immunization coverage of 41% for BCG, 79% of measles but only 23% for triple vaccine and polio.

Source: Pinto, R, Avaliação dos Programas de Saúde Apoiadas pela ASDI na Província de Huíla, Julho de 1991.

Although the author observed more shortcomings than successes, he underlines the need to continue staff training and capacity building through seminars and courses, since it was possible to verify positive results in some areas of what had already been done.

The situation in Luanda

In Luanda, the interview team talked to the Provincial Delegate and managers who were administrating the programmes at provincial level and a relatively big group of people working at four of the Health Centres in the province.

In Luanda all the programmes were anchored at the Provincial Health Delegation⁴², where each programme had an appointed manager (except training, which “belonged” to the MoH and HIV/AIDS, which had not started yet). Although the Delegation is situated in the city centre, managers had similar complaints as the ones heard in Huíla. The programmes had serious problems with the maintenance of their vehicles, and they were lacking man-

⁴² Currently titled Provincial Directorate of Health.

uals and posters about essential drugs to distribute at the Health Centres and Hospitals. Several managers complained about the lack of motivation and low professional level among the staff of the programmes and in the Maternal Health programme the equipment at the Health Units was in a state of decay or stolen.

The Malaria programme had a special problem, which was not directly affecting the other programmes. Greater Luanda was already overcrowded in the beginning of the 1990's and the programme tried to establish collaboration with the *Comissariado Provincial* to eliminate some of the more evident health risks, through improving the environmental sanitary conditions through garbage removal, etc., but without results.

Since the AIDS programme had not yet started, information on HIV/AIDS was disseminated through the Health Education programme at Health Centres, in schools and workplaces, and usually condoms were distributed after information sessions. However, the team could not get any data about number of sessions, etc.

The conditions at the Luanda Health Centres are also rather poor, although all of the four visited had electricity but with unreliable distribution. No Centre had community water supply, but the water tank lorry from the *Comissariado Provincial* was arriving regularly. None of the Centres had a permanent doctor, and the majority of the staff was *técnicos básicos*. Normally Centres were only working during the morning hours, and the number of patients per day/nurse was between five and eleven, this of course averagely depending on the size of the Centre. The most frequent reason for attending the Centre was malaria, for children as well as adults.

Most programmes are implemented at the Centres, with someone appointed to be responsible, except Health Education, Malaria and HIV/AIDS, which are partly taken care of by the other programmes. At the time of the evaluation, the Immunization programme had established fixed vaccination posts at the Health Centres and vaccination was taking place each day in combination with short information sessions. The Essential Drugs programme was distributing drug kits regularly, and all Centres had staff that had been trained by the programme. The Maternal Health programme was working with antenatal care and family planning and one Centre had a small maternity ward. The nurses/midwives do not know the number of pregnant women in their area, since most women give birth to their babies at home. The quality of the antenatal care was not fully satisfactory. There was always a lack of pregnancy cards at the Centres, which makes it difficult to monitor a pregnant woman correctly. Nurses/midwives made no evaluation of possible obstetric risks. The TB programme was working with diagnosis, treatment and follow-up of the patients, but not at all with prevention. Drugs and reagents were distributed by the programme supervisor, but always in insufficient quantity, and supervision is irregular.

At province level, programme managers confirm certain collaboration between the programmes, such as lecturing at seminars and participation in the development of health education material. But in the field the situation is different. The programmes “arrive at the Centres” in a vertical form and the team could for example only find some occasional contacts between the Immunization programme and Maternal Health.

(Recommendations for future development of the programmes are found in the main report.)

Source: Pinto, R. (1992) *Avaliação Especial do apoio ASDI a Programas de Saúde da R.P. Angola. Opinião da Parte Angolana. Dezembro de 1991 e Janeiro de 1992.*

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Healthy Support?

Sida Support to the Health Sector in Angola 1977–2006

Angola is emerging from decades of war with an infrastructure in ruins and some of the worst health indicators in the world. Sweden has supported the health sector in Angola since independence in 1975 up until 2006, when the last development cooperation programmes were phased-out. This study describes Swedish health support over 30 years and the motives behind it. It also analyzes to what extent development cooperation efforts have contributed to improved health in Angola.



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